Witness Name: Albert Heaney
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UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF ALBERT HEANEY

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

Preface

1. I am providing this corporate statement in response to a request under Rule 9 of the Inquiry Rules 2006 referenced M6/HSSG/01 and addressed to the Welsh Government's Health and Social Services Group (HSSG), regarding the role that it had in the Welsh Government's response to the Covid-19 pandemic as it pertained to the adult social care sector in the period 1 January 2020 to 28 June 2022.

2. The impact of the pandemic was devastating. It was devastating to those we lost to Covid-19, to those who lost loved ones, to those who were unable to visit loved ones during their last days, for those who were unable to mourn the sad loss of friends or family, and to those who lost their livelihoods and the ability to provide for their families. I understand the pain and sadness experienced and I wish to extend my deepest sympathies to those who have lost loved ones during the pandemic and to those adversely impacted by it.

3. I want to express my deepest gratitude to care service providers, everyone working in the care system, and to the volunteers, for serving on the front lines of the pandemic and for their tireless commitment to providing support and comfort to our vulnerable citizens and their families. Their dedication, commitment, and courage during a hugely challenging and unprecedented situation did not go unnoticed and will not be forgotten.

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

Background

5. I am a career social worker and my qualifications across the social services and management disciplines include BA (Hons) Sociology with Professional Studies, Certificate in Qualification of Social Work, Certificate in Management Studies, Diploma in Management, Masters in Business Administration, and Certificate in using a Systemic Approach.

6. I have worked in public service since the 1980s, having started work as a social worker within a Welsh local authority. My wider roles have since included: President of the Association of Directors of Social Services Cymru (ADSS Cymru), Lead Director for Children and Lead Director for Safeguarding and Prevention, Chair of a Children's Safeguarding Board, and Corporate Director Social Services leading on Children and Adult Services. I am also a member of the Family Justice Board and Chair of the Family Justice Network Wales.

7. Prior to the pandemic, I was performing the role of Director for Social Services and Integration, providing policy leadership, managing the teams across several divisions and serving as principal policy adviser to ministers. As the Director of Social Services and Integration ('SSID') my responsibilities covered adult and children's social care, defined health policies (for example Continuing Health Care) and health / social care integration. I was overseeing policy teams organised within three divisions.

8. It is important that I make clear at the outset that Social Services and Integration Directorate is a distinct part of the Health and Social Services Group. Shortly after the onset of the pandemic, from March 2020 until June 2021, I combined my role with the role of Deputy Director General, supporting Dr Andrew Goodall CBE, Director General for Health and Social Services, and being ready to act as Deputy as needed. This included representing the group on the Director General's behalf in key fora such as the Welsh Government Executive Committee, commonly referred to as ExCo, and the dedicated Coronavirus-related sub-forum, known as ExCovid.

9. From June 2021 onwards I was appointed to the role of Chief Social Care Officer for Wales, maintaining the responsibilities of the role of Director of Social Services and Integration Directorate with an additional formal role of providing expert advice to ministers on social care matters, and engaging on behalf of the Welsh Government with social care staff and stakeholders.

10. The responsibilities of the Chief Social Care Officer for Wales include:

    i. driving integration between health and social care.
    ii. enabling people in receipt of social care to achieve their personal outcomes.
    iii. supporting innovative and social value models of service delivery.
    iv. promoting improvement and reform in social care.
    v. supporting the wellbeing and development of the social care workforce.
    vi. supporting local authorities and providers and improving quality and sustainability in social care.
    vii. delivering the intentions of the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016.
    viii. driving safeguarding arrangements and procedures to ensure the highest standard of practice.

11. It is in my capacity as Director of Social Services and Integration, Deputy Director General of the Health and Social Services Group (from March 2020 until June 2021), and Chief Social Care Officer for Wales (from June 2021) that I am providing this statement. In producing this statement, I have been assisted by Deputy Director Rhiannon Ivens and officials who were members of Andrea Street's team during the specified period. I describe Andrea's role below. I have also been assisted on some matters by officials from outside my Directorate, who I identify at the relevant part of my statement.

The role of Social Services and Integration Directorate (SSID) within the Health and Social Services Group (HSSG)

12. The Welsh Government was divided into five separate policy Groups, as follows:
    - The Permanent Secretary's Group, led by Permanent Secretary Shan Morgan.
    - Office of the First Minister Group (OFM), led by the Director General Des Clifford.

- Health and Social Services Group (HSSG), led by the Director General / Chief Executive of NHS Wales, Dr Andrew Goodall.
- Economy, Skills and Natural Resources Group, led by the Director General, Andrew Slade.
- Education and Public Services Group, led by the Director General, Tracey Burke.

Each Group is divided into several Directorates, all of which are led by their own Director or other senior role.

13. As noted above, Health and Social Services Group was one of the five Groups, and Social Services and Integration Directorate is one Directorate within the Health and Social Services Group. Social Services and Integration Directorate, led by me, had responsibility for adult social care policy throughout the pandemic (but not delivery of social care, which was the responsibility of the 22 local authorities as I explain below). It is for this reason that Social Services and Integration Directorate is best placed to respond to the Inquiry's Rule 9 request M6/HSSG/01 for information relating to adult social care during the pandemic (even though the Rule 9 request has been directed at the broader group). I explain how my Directorate was structured and functioned during the pandemic below.

Organisational structure of the Welsh Government and the Health and Social Services Group

Devolution, the First Minister, and the Welsh Ministers

14. The Government of Wales Act 2006 ("GoWA 2006") sets out the statutory framework which underpins devolution in Wales, establishing the Senedd Cymru ("the Senedd") with powers to make laws (legislative functions) and the Welsh Government which provides Welsh Ministers with executive functions.

15. The Welsh Government was established by section 45 of the Act, defining the following:

i. Prif Weinidog, or First Minister;

ii. Gweinidogion Cymru; or Welsh Ministers;

iii. Cwnsler Cyffredinol i Lywodraeth Cymru, or the Counsel General to the Welsh Government; and

iv. Dirprwy Weinidogion Cymru, or Deputy Welsh Ministers.

16. The Welsh Government is the 'executive' and exercises its functions and powers independently of the Senedd which is the 'legislature'. In broad terms those executive functions of the Welsh Government arise in the following key areas of public policy: health; social services; local government; education; transport; planning; economic development; culture; Welsh language; environment; agriculture and rural affairs.

17. The First Minister of Wales is the leader of the Welsh Government and keeper of the Welsh seal. The First Minister chairs the Welsh Government Cabinet and is primarily responsible for the formulation, development and presentation of Welsh Government policy. Additional responsibilities of the First Minister include promoting and representing Wales in an official capacity, at home and abroad, and responsibility for constitutional affairs as they relate to devolution and the Welsh Government. The First Minister is a Member of the Senedd ("MS") and is nominated by the Senedd before being officially appointed by the Monarch. Members of the Welsh Cabinet and Ministers of the Welsh Government, as well as the Counsel General, are appointed by the First Minister. As head of the Welsh Government, the First Minister is directly accountable to the Senedd for the Welsh Government's actions. The Rt Hon. Mark Drakeford MS became the First Minister of Wales on 13 December 2018 and remained in office throughout the pandemic period.

The Minister for Health and Social Services

18. The Minister for Health and Social Services (Welsh: Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) is a Cabinet position in the Welsh Government, held by Vaughan Gething MS from 2016 to 12 May 2021 when he was succeeded by Eluned Morgan MS, following the Senedd elections in May 2021. During the pandemic, the Minister for Health and Social Services was responsible for:

i. Preparedness for the NHS and health sector, NHS initial capacity and ability to increase capacity and resilience.

ii. The management of the pandemic in all health care settings, including infection prevention and control, triage, critical care capacity, the discharge of patients,

the use of 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels.

iii. Shielding and the protection of the clinically vulnerable.

iv. Taking a central role in discussions around the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings (but these decisions were principally made by the First Minister following discussion and agreement at Cabinet).

v. International travel restrictions.

vi. The procurement and distribution of key equipment and supplies, including personal protective equipment (PPE) and ventilators.

vii. National testing programme.

viii. National vaccination programme.

ix. The consequences of the pandemic on provision for non-Covid-19 related conditions and needs.

x. Oversight of the health data and evidence.

xi. Policy and oversight of the provision of all social service activities of local authorities in Wales, including the issue of statutory guidance.

xii. Regulation of residential, domiciliary, adult placements, foster care, under 8s care provision and private healthcare.

xiii. Early years, childcare and play, including the childcare offer and workforce.

The Deputy Minister for Social Services

19. The Government of Wales Act (2006) also provides for the appointment by the First Minister of Deputy Ministers; from December 2018 and throughout the pandemic period, Julie Morgan MS was the deputy minister with responsibility for social services, supporting the Minister for Health and Social Services who retained overall responsibility for the health and social care system in Wales. Specifically, the Deputy Minister's responsibilities were:

i. Safeguarding, adoption and fostering, children and young people's advocacy including complaints, representations and advocacy under the Social Services and Well-being (Wales) Act 2014, Information sharing under the Children Act 2004, CAFCASS Cymru.
ii. Children and young people's rights and entitlements including the UN Convention on the Rights of the Child, early years childcare and play including the childcare offer and workforce, early childhood education and care, Flying Start, Families First and play policies.
iii. Policy and oversight of the provision of social services activities of local authorities in Wales, including statutory guidance, oversight of Social Care Wales.
iv. Regulation of residential, domiciliary, adult placements, inspection of and reporting on the provision of social services by local authorities (via Care Inspectorate Wales) including joint reviews of social services and responding to reports.
v. Policy related to carers and older people.

20. At the beginning of the pandemic period, Julie Morgan was the Deputy Minister for Health and Social Services, but her responsibilities were focused on social services (as set out above), and her ministerial position was renamed Deputy Minister for Social Services following the May 2021 Senedd elections.

The Welsh Government's Health and Social Services Group (HSSG)

21. The Health and Social Services Group supports the Welsh Ministers and reports to the Minister for Health and Social Services. In March 2024 the Group structures within the Welsh Government were changed; but as this change took place outside the Inquiry's specified period, I shall refer to the Group as it was throughout the pandemic.

22. During the pandemic the Health and Social Services Group consisted of the following directorates:

i. Cafcass Cymru;

ii. Delivery, Performance and Planning for health and care in Wales;

iii. Finance;

iv. Mental Health, Vulnerable Groups and NHS Governance;

v. Nursing;

vi. Population Health (including the Chief Medical Officer's Office);

vii. Primary Care and Health Science;

viii. Social Services and Integration (SSID);

ix. Technology, Digital and Transformation; and

x. Workforce and Organisational Development.

23. The Health and Social Services Group was led by a Director General, who is also the Chief Executive of the NHS in Wales. At the beginning of the pandemic period the Director General for the Health and Social Services Group was Dr Andrew Goodall. In November 2021, Andrew Goodall became the Welsh Government's Permanent Secretary and was succeeded as Director General for the Health and Social Services Group by Judith Paget. The Director General role is inward facing, meaning that it is a role within the Welsh Government. This is in contrast to the Chief Executive role, which held responsibility over NHS entities in Wales (which are external to the Welsh Government). Neither the Chief Executive NHS Wales role nor the bodies collectively known as the NHS in Wales have statutory responsibilities for the delivery of social care services in Wales under the 2014 Social Services and Well-being (Wales) Act: these responsibilities sit with the local authorities as I have described.

24. In March 2020, the Director General asked me to undertake the role of Deputy Director General for the Health and Social Services Group. This was in addition to my responsibilities as Director of the Social Services and Integration Directorate. This assisted Dr Andrew Goodall to focus on his Chief Executive NHS Wales role during this period of extreme pressure. The Director General and I met regularly throughout the pandemic, including through our participation in regular meetings such as the

weekly meetings of the Health and Social Services Group Directors (the Executive Directors' Team).

The Social Services and Integration Directorate (SSID)

25. The structure of the Social Services and Integration Directorate is set out in the organogram which I exhibit as **AH2/001-INQ000495978**. During the relevant period Social Services and Integration Directorate consisted of three divisions:

    a. The Partnership and Co-operation Division, which was led by Deputy Director Matthew Jenkins and broadly, had oversight of policy relating to support for carers and older people, and funding.

    b. The Improvement Division, which was led by Deputy Director Andrea Street and broadly had oversight of the regulation and inspection of social care services policy, policy on the social care workforce, and domiciliary care.

    c. The Enabling People Division, which was led by Deputy Director Alistair Davey and broadly had oversight of policy on children's homes and safeguarding.

26. Prior to the pandemic, the Social Services and Integration Directorate had well established stakeholder relationships and communications channels. These included regular meetings and communication with statutory directors of social services and the Association of Directors of Social Services Cymru. In addition, a ministerial-level National Partnership Board was established comprising representative social care stakeholders, together with ministerial advisory forums and groups, for example in relation to learning disability, older people, looked after children, and unpaid carers. Frequent meetings were also held with a wide range of stakeholders across statutory commissioners and provider representative organisations via the National Commissioning Board, Regional Partnership Board leads and chairs, local government partners and Welsh Local Government Association members, third sector organisations, and service user representatives at official and ministerial levels.

27. During the pandemic this pre-existing infrastructure and approach was extensively supplemented by bespoke mechanisms such as the Covid-19 Planning and Response Social Care Subgroup outlined below in paragraphs 47-48. This group advised both on pandemic response and in relation to lessons learned after the first phase. A further layer of additional engagement was provided by a major uprating of existing

engagement such as weekly meetings hosted by both the Deputy Minister and Deputy Director General with the Older People's Commissioner, and weekly ministerial meetings with representatives of social care providers, as well as the establishment of the Social Care Testing Leads forum which included testing leads from local authorities and local health boards.

28. In addition, during the pandemic I nominated Deputy Director Andrea Street to oversee the Social Services and Integration Directorate's Covid-19 response, and I directed a Covid Social Care Coordination Hub to be established. Importantly, Andrea Street established a series of workstreams which were staffed by Social Services and Integration Directorate colleagues. This helped enable the directorate to have a role in a wide range of topics which were relevant to social care, including PPE, testing, vaccination rollout, communications, care home visiting, food supply to care homes and vulnerable people, and easements to relevant social care legislation. A copy of the Directorate's Covid-19 workstreams organogram is exhibited at **AH2/002-INQ000502005** and includes further detail, such as timing of staff leading each workstream. This structure changed as the pandemic progressed, with some of those workstreams (such as that on food availability) stood down as systems were put in place or issues eased, and others stood up (for example on vaccination).

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

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

    - Dr Andrew Goodall CBE, Director General, Health, and Social Services Group until November 2021
    - Judith Paget CBE, Director General, Health, and Social Services Group since November 2021

- Sir Francis Atherton, Chief Medical Officer for Wales
- Dame Shan Morgan, Welsh Government Permanent Secretary.

Legislative background to Social Services and Social Care in Wales

31. Statutory responsibilities for social care are vested in local authorities under the Social Services and Well-being (Wales) Act 2014 ('the 2014 Act'), as supplemented by regulations, statutory guidance and codes of practice made under that Act. Social services are delivered by the 22 Welsh local authorities as detailed in exhibit **AH2/003-INQ000083226.**

32. The Health and Social Services Group's role and responsibilities in relation to social care are therefore fundamentally different to those it has for the NHS in Wales. The Welsh Ministers are responsible under the NHS (Wales) Act 2006 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. This meant that my roles as Deputy Director General, Health and Social Services, and subsequently Chief Social Care Officer for Wales, covered social care policy rather than the operational delivery of social care services, responsibility for which sat solely with the 22 local authorities in Wales. Nor does the Welsh Government directly fund the delivery of social services and social care: this is funded by the local authorities.

33. The aim of the 2014 Act requires all persons and bodies exercising functions under the Act to promote the well-being of people who need care and support, and that of carers who need support.

34. Well-being under the 2014 Act covers a wide range of aspects of daily life, such as physical, mental, and emotional well-being; protection from abuse; and family and personal relationships. Additionally, due regard must be given to the United Nations Principles for Older Persons[1] and the United Nation Convention on the Rights of the Child[2].

[1] Section 7 of the 2014 Act
[2] Section 7 of the 2014 Act, note that section 6(3) of the Act notes the duty to have due regard to the UNCRC will be in the form set out in the Rights of Children and Young Persons (Wales) Measure 2011, which includes the UNCRC optional protocols.

35. The duty on local authorities to provide social services encompasses a wide range of services. Section 34 of the 2014 Act provides examples including, accommodation in a care home, children's home, care and support at home or in the community, information and advice, social work, counselling, advocacy and other services.

36. The 2014 Act requires local authorities to follow statutory guidance, or a code issued by the Welsh Ministers and to heed relevant guidelines contained in it[3].

Integration of Health and Social Care in Wales

37. In 2018, 'A Healthier Wales' (exhibited at **AH2/004-INQ000066130**) was published by the Welsh Government setting out its long-term plan to integrate health and social care, adopting a key principle of the 2014 Act to provide integrated and sustainable care and support services. The intention behind this long-term goal of integrated health and social care is to secure better joint working and more effective services which best meet the needs of the local population.

38. 'A Healthier Wales' refers to seamless health and social care promoted by and through Regional Partnership Boards. The Social Services and Well-being Act 2014 provided for the establishment of seven Regional Partnership Boards, which brought together health boards, social services, third sector and other partners[4]. Regional Partnership Board members jointly assess, plan, and provide efficient and effective services for their area to improve the outcomes and well-being of people with care and support needs and for carers who need support.

Groups within the Welsh Government relevant to adult social care

39. The Welsh Government comprised a number of groups and bodies that had a key role in informing and shaping the response of the health and social care systems to Covid-19 throughout the pandemic period, and I set out below a summary of the specific

[3] Section 145 of the 2014 Act.
[4] The Partnership Arrangements (Wales) Regulations 2015 ("the 2015 regulations") prescribe the requirements for each Local Health Board and the local authorities within their area to take part in partnership arrangements for the carrying out of specified health and social services functions.

groups about which I have been asked and which were relevant to the work of Social Services and Integration Directorate.

Technical Advisory Group (TAG) and Technical Advisory Cell (TAC)

40. I understand that the Technical Advisory Cell was established to collate, create and mobilise knowledge related to the pandemic, including Welsh specific information, to support decision making by Welsh Ministers. The Technical Advisory Cell was established on 27 February 2020. The size and scale of the demand for scientific information and lack of a national coordination function to meet this demand ultimately led to the formation of the Technical Advisory Group, which I understand was formalised by Terms of Reference approved in a Ministerial Advice on 28 April 2020, exhibited at **AH2/005-INQ000068498.**

41. For clarity, the Technical Advisory Group was the main source of expert advice during the pandemic period in Wales. The Technical Advisory Group consisted of internal (civil servants) and external (non-civil servants) scientific and technical experts who provided independent science advice and guidance to the Welsh Government in response to Covid-19.

42. The role of the Technical Advisory Group during the pandemic in relation to social care was essential, particularly with regard to the identification of vulnerable groups, such as the elderly or those with underlying health conditions. This guidance informed the Welsh Government's policies on shielding and targeted social services support for example. The Group's advice often encouraged the integration of public health measures with social services which recognised that effective public health responses needed to address not only the virus but also the social determinants of health.

Covid-19 Analysis hub

43. As a result of increasing analytical demand, the Welsh Government's Knowledge and Analytical Services division established a Covid-19 analysis hub, which was in operation from 23 March 2020. The hub provided a central point of coordination within the Welsh Government for Covid-19 data and statistics.

44. This hub was relevant to social care and the Social Services and Integration Directorate because it provided real-time data and analysis that informed policy development. The integration of Covid-19 data allowed for a more responsive and targeted approach to managing the impact of the pandemic on vulnerable populations, including those relying on social care services. The data driven insights from the hub helped the Directorate anticipate needs, allocate resources effectively, and adjust services to protect health and well-being of both service users and providers.

Health and Social Services Planning and Response Group

45. In February 2020, Andrew Goodall established the Health and Social Services Group Coronavirus Planning and Response Group (HSSG Planning and Response Group), which was chaired by Samia Edmonds and vice-chaired by Gillian Richardson, Senior Professional Advisor to the Chief Medical Officer for Wales. This group reported to Andrew Goodall and Frank Atherton, Chief Medical Officer for Wales. The Health and Social Services Planning and Response Group brought together strategic representatives of the Group, NHS bodies, and social care. Its role was to consider the latest Reasonable Worst-Case Scenarios for Covid-19 risk assessment, co-ordinate contingency response planning, share information and communications to raise awareness on contingency arrangements and actions, and provide a strategic interface for health, social care services and Health and Social Services Group officials.

46. There were seven sub-groups of the Planning and Response Group established to co-ordinate action and manage systems risks across a number of areas, one of which was social care.

47. The Social Care sub-group was co-chaired by myself and Andrea Street and its membership was drawn from key stakeholders across the social care sector including local authority Directors of Social Services, the Welsh Local Government Association, Social Care Wales, and Care Inspectorate Wales. The group also included members that provided significant input from co-dependent areas such as housing, British Red Cross, Wales Council for Voluntary Action, Care Forum Wales, and Community Health Council. The group was actively used as a networking platform to seek views, test ideas and cascade information between the sector and the Welsh Government. During the first six months of the pandemic, these meetings were held approximately once per week.

48. The group provided advice, guidance, and leadership for all care settings in Wales and focused not only on short term immediate issues/actions in relation to the pandemic but also began to consider medium to long-term considerations (for example winter preparedness, consideration of future Covid-19 waves and efforts to return to a business as usual or Covid-19 stable position). The group focused upon registered care homes for adults and children; domiciliary care; supported living; learning disability 'shared lives' arrangements; personal assistants; and unpaid carers.

49. As part of the Health and Social Services Group Covid-19 planning and response structure, I was a member of another informal group along with Frank Atherton, Jean White, the Chief Nursing Officer for Wales; and Samia Edmonds, Chair of the Covid-19 Planning and Response Group; all of whom reported to Andrew Goodall as Director General of Health and Social Services. In terms of structure, this sat between the Minister for Health and Social Services and the Health and Social Services Planning and Response Group, but in practice it was a regular meeting and contact point for the sharing of information. These meetings covered general updates and sharing of information from the various sub-groups, meetings and interactions that we were all engaged in during this period, to ensure a coordinated approach could be taken.

50. This group was referred to as the Executive Directors Daily Call. I exhibit as **AH2/006-INQ000083237** (dated 20 April 2020) (see slide two) a structure chart showing the group (located between the Minister for Health and Social Services and the Health and Social Services Planning and Response Group). These meetings were held to co-ordinate information from across the Group. I understand that as it was a relatively informal information sharing meeting and as such formal notes were not circulated.

Covid-19 Moral and Ethical Advisory Group Wales

51. The Covid-19 Moral and Ethical Advisory Group Wales (known as CMEAG) was established to gather and co-ordinate issues relating to moral, ethical, cultural and faith considerations, and to provide a source of advice to public services on issues arising from the health and social care emergency response to the Covid-19 pandemic.

52. The terms of reference of the Covid-19 Moral and Ethical Advisory Group Wales were published on 4 May 2020, and are exhibited at **AH2/007-INQ000066079**.

53. Membership of the Covid-19 Moral and Ethical Advisory Group Wales was constituted from Wales-wide communities affected by the Covid-19 pandemic, including those at risk of more disproportionate impacts. Expertise was shared from the fields of clinicians; public health; academic; legal; social and behavioural sciences; media and communications. The group could co-opt additional members and expertise as needed for specific issues.

54. The Covid-19 Moral and Ethical Advisory Group considered a number of issues including priority areas for attention in maintaining essential NHS services. It also considered social care matters, such as the moral and ethical aspects of care home visiting. A copy of the *Coronavirus: ethical values and principles for healthcare delivery framework* is exhibited in **AH2/008-INQ000081000**.

Social care testing and infection control strategy and policy development group

55. In November 2020, the Social Services and Integration Directorate established a social care testing and infection control strategy and policy development group. I chaired this during the early stages of the pandemic; the group facilitated the co-ordination of clinical, social care sector and operational intelligence to inform the design and implementation of testing and infection control strategies and policy for social care. The group met for the first time on 16 November 2020 and continued to meet every two to four weeks throughout the remainder of the specified period. I exhibit the Terms of Reference at **AH2/009-INQ000198526**.

Nosocomial Transmission Group

56. Members of my team also regularly attended the Nosocomial Transmission Group, which was established on 19 May 2020 and stood down on 28 March 2022. This was a health-led group, jointly chaired by the Welsh Government's Deputy Chief Medical Officer for Wales and the Chief Nursing Officer for Wales.

57. The purpose of the group was to provide advice, guidance and leadership on the actions needed to minimise the nosocomial transmission of Covid-19, and to enable

the safe resumption of routine services in health and social care settings. The work covered hospitals, primary and community care settings, prisons, registered care homes, domiciliary care, and learning disability facilities. The group developed and oversaw the implementation of infection prevention and control measures, including patient and staff isolation and testing. I produce here the terms of reference of the Nosocomial Transmission Group, as exhibit **AH2/010–INQ000252576**.

Social Care Fair Work Forum

58. The Social Care Fair Work Forum (which was initially known as the Social Care Forum) is a tripartite social partnership group committed to embedding fair work and improving terms and conditions for those working within the social care sector. It allows representatives of trade unions, employers, stakeholders, and the Welsh Government to work together to influence national priorities and policy regarding fair work in the social care sector in Wales. The forum has an independent chair (Professor Rachel Ashworth, who is a Professor in Public Services Management at Cardiff University) and draws its membership from these organisations:

i. The Welsh Government
ii. Trade Unions: GMB, Unison, Royal College of Nursing, Wales Trades Union Congress
iii. Employers: Welsh Local Government Association, Care Forum Wales, Association of Directors of Social Services Cymru, National Provider Forum
iv. Social Care Wales

59. The Forum met for the first time on 10 September 2020; I exhibit its Terms of Reference at **AH2/011-INQ000496059**.

Health and Wellbeing Sub-Group

60. The Health and Wellbeing Sub-group of the Workforce Deployment and Wellbeing Response Group (Workforce Cell) which was established on 14 April 2020 as part of the Health and Social Services Planning and Response Group, took the lead on health and wellbeing. This group was made up of individuals from the NHS in Wales, trade unions and the Welsh Government and was another example of collaboration across organisations. This group was stood down in June 2020 and the sub-group's Transition Plan, as exhibited in **AH2/012-INQ000227420** provides a summary of the

group's aims and how its work would continue as part of business-as-usual programmes.

Recovery planning, and the Reconstruction and Stabilisation Boards

61. The leading forum through which members of the Health and Social Services Group contributed to wider recovery plans across the Welsh Government was the internal-facing Continuity and Recovery Board, chaired by Jeremy Miles MS, who at that time was Counsel General and Minister for European Transition. Andrew Goodall represented the Health and Social Services Group on this Board, which was used to consider the complex and cross-cutting issues that arose as Wales emerged from the first wave of the pandemic and prepared for the end of the UK/EU Transition period. I represented the Social Services and Integration Directorate on the Recovery Board.

62. Within the Health and Social Services Group, both the Planning and Response Group and the Stabilisation and Reconstruction Scoping Board were responsible for the development, implementation and assessment of recovery plans specific to health and social care. The Health and Social Services Group Stabilisation and Reconstruction Scoping Board was established to focus on the integrated health and social care response to Covid-19. This included understanding the impact of Covid 19 across all areas of the sectors, analysing this impact, modelling for the future and ensuring that the most recent data and evidence was used to inform this work. This board was chaired by Sioned Rees.

63. To complement the Health and Social Care Stabilisation and Reconstruction Scoping Board, my Directorate also established a Social Care Stabilisation and Reconstruction Board. This was a board of internal Welsh Government colleagues and key stakeholders from across the sector including the Association of Directors of Social Services Cymru, Care Inspectorate Wales, leads from Regional Partnership Board and third sector representatives. This board was chaired by Enabling People Deputy Director Alistair Davey, Social Services and Integration Division. I exhibit at **AH2/013-INQ000514862** a paper prepared which provides more information about the rationale for the establishment of the Social Care Stabilisation and Reconstruction Board.

64. These Stabilisation and Reconstruction Boards oversaw the production of the 'Health and Social Care in Wales – Covid-19: Looking forward' plan published on 22 March 2021 (**AH2/014-INQ000066129**). This was followed by a specific framework for social

care on 22 July 2021, titled 'Improving Health and Social Care (Covid-19 Looking Forward) Social Care Recovery Framework' exhibited as **AH2/015-INQ000083254,** dated 22 July 2021). Both aligned with the Welsh Government's broader Continuity and Recovery Programme.

65. The purpose of the Social Care Recovery Framework was to provide an overarching structure which could support the social care sector to plan for recovery. Individual organisations were asked to develop their own recovery planning approaches, informed by the Social Care Recovery Framework. The Framework described structural considerations, issues, and themes, which would need to be considered as part of effective recovery planning.

Groups external to the Welsh Government relevant to adult social care

66. The Welsh Government engaged regularly with the following external organisations that were relevant to the formulation of adult social care policy during the pandemic.

Welsh Local Government Association

67. I had frequent calls with Welsh Local Government Association in the early stages of the pandemic and they were also part of the Social Care Stakeholder Communications Group, which was set up alongside the Planning and Response Group to ensure rapid communication of key messages with external and internal stakeholders.

68. There were also regular calls with the Welsh Local Government Association as part of wider Welsh Government engagement, chaired by the Minister for Housing and Local Government and which I attended on occasion.

Association of Directors of Social Services Cymru

69. I met with the Association of Directors of Social Services Cymru (ADSSC) on a very regular basis during the pandemic period. The frequency of meetings varied as the pandemic progressed, beginning with weekly in the early part of the pandemic and reducing over time. I would also regularly link with key leads for the Association of Directors of Social Services Cymru (such as Alison Bulman and Nicola Stubbins), as well as other local authority Directors of Social Services.

70. These meetings offered an opportunity to discuss a wide range of issues and concerns; for example, funding support, testing in care homes, or localised lockdown arrangements.

71. I also sent letters to Directors of Social Services where required, for example, to inform them when new guidance was being issued to the sector. I exhibit several such letters later in my statement.

Public Health Wales

72. The Social Services and Integration Directorate regularly sought advice and guidance from Public Health Wales on a range of matters relevant to social care policy, as set out later in my statement. More specifically, Public Health Wales was represented on groups and committees that were relevant to the Directorate's work during the pandemic, including the Care Home Visiting Stakeholder Group convened by Care Inspectorate Wales, and the Social Care Testing and Infection Prevention and Control Group.

Care Inspectorate Wales

73. During the pandemic, the Social Services and Integration Directorate maintained very close links with Care Inspectorate Wales across a range of matters relating to adult social care. In addition to the Care Home Visiting Stakeholder Group, the Social Care Testing and Infection Prevention and Control Group, and the Social Care Stakeholder Communications Group, Care Inspectorate Wales also attended some ministerial meetings on social care, for example to discuss issues in relation to PPE and testing capacity.

Social Care Wales

74. Social Care Wales is and was during the pandemic the professional body for the social care sector in Wales. Social Care Wales was represented at various groups, such as the Care Home Visiting Stakeholder group, and the Planning and Response Social Care Subgroup. In the initial stages of the pandemic, I chaired a weekly call with leads in the adult social care sector, which Social Care Wales attended.

Others

75. Social Services and Integration Directorate also engaged with the following key stakeholder organisations during the pandemic:
    - The Older People's Commissioner for Wales
    - The Equality and Human Rights Commission (Wales)
    - Care Forum Wales
    - Regional Safeguarding Boards
    - Regional Partnership Boards
    - The Children's Commissioner for Wales

Engagement with the UK Government, the Scottish Government and the Northern Ireland Executive

76. I am asked to provide information about levels of engagement and collaboration with the UK Government, and with the Scottish Government and the Northern Ireland Executive.

Engagement between the Welsh Government and the UK Government during the early months of the pandemic

77. I set out below a high-level summary of the engagement between the Welsh Government and the UK Government during the early months of the pandemic. In providing this summary I have relied upon evidence provided to Module 2B of the Inquiry by Dr Andrew Goodall.

78. One of the key meetings in which there was engagement across the UK during the early months of the pandemic was the Cabinet Office Briefing Room (COBR) meetings. These were the highest level of engagement between the Welsh Ministers, the Prime Minister and his Ministers, as well as the senior members of the Devolved Governments. The first Covid COBR meeting relating to Covid-19 took place on 24 January 2020, which the Minister for Health and Social Services attended. Representatives of the Welsh Government were invited to subsequent COBR meetings; the Minister for Health and Social Services initially attended COBR supported by civil servants and as the pandemic gained momentum, the First Minister also attended.

79. Ministerial Implementation Groups (MIGs) were a four-nation discussion fora established on 16 March 2020 by the then Prime Minister, Boris Johnson MP in response to Covid-19. Four Ministerial Implementation Groups were established, the detail of which is set out below:

- The Healthcare Ministerial Implementation Group, the main focus of which was NHS preparedness and notably ensuring capacity in the critical care system for those worst affected, along with the medical and social package of support for those encompassed in the shielding regime. Terms of Reference included social care capacity and preparedness. The Minister for Health and Social Services attended most meetings of this Group.
- The General Public Sector Ministerial Implementation Group focused on preparedness across the rest of the public sector and critical national infrastructure. Several Ministers from the Welsh Government attended this Group, including the Minister for Health and Social Services, the Minister for Housing and Local Government, and occasionally the First Minister.
- The Economic and Business Response Ministerial Implementation Group, whose main focus was on the economic and business impact and response, including supply chain resilience. The Welsh Government Minister for Economy and Transport principally attended this meeting.
- The International Ministerial Implementation Group focused on international coordination; as this was principally an area reserved to the UK Parliament, the Welsh Government had less involvement in the group.

80. From around August 2020 and after the Ministerial Implementation Groups had ceased meeting, the Chancellor of the Duchy of Lancaster established a meeting, which usually took place weekly between the leaders of the four nations to discuss Covid-19 related matters. This was a four nations meeting, and these meetings took place regularly throughout the pandemic period. Social care matters featured regularly in the discussions at these meetings.

81. Welsh Government officials attended and participated in frequent SAGE meetings from 11 February 2020, which was the 6th SAGE meeting. Attendance continued throughout the SAGE Covid-19 programme.

82. There was also continued engagement across the four Chief Medical Officers (CMOs). I understand that on 24 January 2020 the first of the four CMO meetings took place and that these meetings frequently continued as the pandemic progressed.

83. In addition to the head of department meetings referred to above, four nations Permanent Secretary coronavirus meetings were established between the three Permanent Secretaries and Chris Wormald (Permanent Secretary at the UK Government Department of Health and Social Care). Dame Shan Morgan represented the Welsh Government.

84. There were also Cabinet Secretary-chaired COBR-O meetings: these were weekly sub-committee Ministerial meetings to discuss various issues, including social care, funding and latterly international travel. These were attended by the Minister for Health and Social Services and senior officials working on international travel.

Social Services and Integration Directorate four Nations engagement

85. The Social Services and Integration Directorate engaged with the UK Government and other devolved governments during the pandemic. There was the Four Nations Group, which was also referred to as the Four Nations Call and by other titles, which was established by the UK Government, enabling open and confidential discussions among the UK and devolved governments. This forum allowed participants to share information and raise broad concerns about the pandemic's impact on adult social care. A designated Social Services and Integration Directorate official served as the representative for these meetings, collaborating with other Social Services and Integration Directorate colleagues to contribute once the agenda was set.

86. During the peak of the pandemic, these meetings were held bi-weekly. The UK Government acted as the secretariat, organising the meetings and allowing members to propose agenda items. The initiator of each agenda item would outline the issue, leading to discussions on whether similar concerns were present in other nations. As the pandemic's severity decreased and scientific knowledge advanced, the frequency of these meetings was reduced to once a month.

87. The engagement among the four nations was open and direct, facilitating a better understanding of each nation's challenges. While some concerns were common

across nations, some issues were unique to specific regions. Feedback from these meetings was promptly shared with directorate colleagues, informing them of developments across the UK.

88. Although the meetings did not make direct decisions, they played a role in information sharing and highlighting common concerns, such as social care workforce capacity and PPE, and the need for financial support for statutory sick pay in the social care sector. They also helped to connect officials across the UK.

89. Information was generally shared in a clear and timely manner. The group worked to mitigate delays and maintained open communication. As the pandemic evolved, each nation prioritised specific issues. For instance, Wales introduced a special payment for social care staff, which lead to similar considerations in other nations.

90. Contact was also made with the other nations outside of the Four Nations Group via specialised meetings convened to address specific policy issues such as PPE, vaccinations, workforce, and financial support. For example, staff in my directorate who focused on care home visiting policy established contact with counterparts in England, Scotland, and Northern Ireland. Initially organised and led by Department of Health and Social Care officials, these meetings evolved into regular, informal discussions between officials from the four nations. These meetings provided an opportunity to exchange information and address challenges, though they were not decision-making forums and were not minuted. Social Services and Integration Directorate officials attended these meetings to provide updates and insights on the relevant topics. Although no formal terms of reference were established, the meetings served as a platform for updating each nation on actions taken to support the social care sector.

International cooperation

91. I do not recall specific Health and Social Services Group engagement at an international level in relation to adult social care. However, I am aware that Care Inspectorate Wales engaged with regulatory counterparts in other countries to understand their experiences of pandemic response.

Welsh Government Funding

92. I am asked to provide information about Welsh Government and local government funding. In doing so in the sections below I have drawn upon information provided in the Module 2B statements of Andrew Goodall (WT-01) and Reg Kilpatrick (LGD-01).

93. The Welsh Government had, immediately before the pandemic, four principal sources of funding:

    i. Funds granted by the UK Government under the annual 'block grant'. That is the principal source of funding,

    ii. Funds raised in Wales by means of taxation and other charges,

    iii. Borrowing,

    iv. EU funding.

94. HM Treasury controls the overall level of public expenditure in the UK. A portion of the total funds raised throughout the UK and earmarked for public expenditure is allocated to Wales. That portion is known as the 'block grant'; it exceeds 80% of the Welsh Government's annual financial resource and it is the largest part of its annual budget. Adjustments to the block grant are determined using the Barnett Formula. It is used to calculate how the block grant will change following an increase or decrease in the UK budget for public expenditure. The formula factors in the population in Wales compared to (usually) England, and the extent to which changes to the UK budget are made in areas where public service provision in Wales is comparable with that in (usually) England.

95. Under Part 5 of the Government of Wales Act 2006, the block grant is paid initially to the Secretary of State for Wales, who retains the funding needed to run the Wales Office. They then make provision for the balance to be accessed, on demand, by the Welsh Government by the Welsh Consolidated Fund (the Welsh Government's bank account). The Welsh Government must then prepare its draft budget setting out how it will use the funds. Senedd committees and other interested parties scrutinise and comment on the draft Budget before it is finalised and approved by a vote of the Senedd in the annual budget motion.

96. The Welsh Government's budget is organised by Main Expenditure Groups (MEGs), which broadly mirror ministerial responsibilities. That provides clear lines of financial

accountability at Cabinet and to the Senedd. The minister with responsibility for finance is responsible for agreeing the Main Expenditure Group budget structure. The Health and Social Services Group Main Expenditure Group is the responsibility of the Minister for Health and Social Services, who sets the funding levels for specific spending programmes, although additional funding is sometimes allocated directly by the Minister for Finance.

97. The Health and Social Services Group's Main Expenditure Group is not however the primary source of funding for the delivery of social services and social care, responsibility for which sits with local authorities. The majority of Welsh Government's funding to local authorities sits within the Main Expenditure Group that is aligned to the Minister with responsibility for local government in Wales. I describe the sources of funding for local government below.

Local Government funding

98. In the section below, I have again drawn upon information provided in the Module 2B statements of Andrew Goodall (WT-01) and Reg Kilpatrick (LGD-01). Local government revenue spending for principal councils in Wales is funded from three major sources:

    i. Welsh Government – with non-domestic rates this accounts for around 80% of total local government net revenue expenditure. It is made up of the Revenue Support Grant, pooled non-domestic rates, and a large number of grants for specific purposes. The Revenue Support Grant is distributed to the 22 authorities through a needs-based formula which is set and reviewed by a joint Welsh Government and local authority working group. The funding allocated is available for the authority to spend as it sees fit on the range of services it is responsible for and as agreed through the local authority budget processes.

    ii. Non-domestic rates – This is a local tax on non-domestic property which is mainly collected from local ratepayers by local councils. The tax-rate (multiplier) is set annually by the Welsh Government. Each council contributes the amount it collects to a central pool managed by the Welsh Government which then distributes the money, together with rates collected centrally, as funding to councils as part of the annual settlements.

iii. Council tax – A local tax on domestic property which accounts for around 20% of total net revenue funding for principal authorities. The tax-rate is set annually by each council individually as part of its budget-setting process. The Welsh Government has powers to limit (cap) council tax increases, but its policy position is to allow local authorities autonomy to set increases as they judge appropriate.

99. Local authorities also raise money through fees, charges, and investments; and the UK Government provides funding to local authorities in Wales to deliver certain non-devolved functions.

100. The table below sets out the levels of local government core revenue funding in Wales for each financial year which falls wholly or partly within the specified period. I also exhibit the letters which are sent each year to Leaders of county and county borough councils in Wales by the Welsh Minister with responsibility for local government funding, confirming the level of funding.

Financial year	**Local government core revenue funding (£ millions)**	**Exhibited letter to Leaders of county and county borough councils in Wales**
2019-20	4,237	Letter from Julie James MS, Minister for Housing and Local Government dated 18/12/2018 (**AH2/016-INQ000492876**)
2020-21	4,474	Letter from Julie James MS, Minister for Housing and Local Government dated 25/2/2020 (**AH2/017-INQ000492877**)
2021-22	4,651	Letter from Julie James MS, Minister for Housing and Local Government dated 2/3/2021 (**AH2/018-INQ000492878**)
2022-23	5,100	Letter from Rebecca Evans MS, Minister for Finance and Local Government dated 1/3/2022 (**AH2/019-INQ000492879**)

101. The funding allocated to each authority is available for that authority to spend as it sees fit on the range of services it is responsible for and as agreed through local authority budget processes. The Welsh Government does not direct local authorities to allocate defined levels of expenditure to any of the services the local authorities are required by law to deliver; local authorities have their own democratic mandate from their electorates (from whom they raise revenue through council tax) and are best placed to identify, understand, and respond to local needs and priorities, including those for the provision of social care.

102. The processes by which local authorities go about setting their budget are not a matter upon which I can comment in any detail, but I offer a high-level outline below.

103. All local authorities will have a Medium-Term Financial Strategy, which covers estimated revenue income and expenditure over the following three years, along with a similar plan for capital expenditure. The budget for the following financial year (i.e. year one of the Strategy) is then considered in more detail, leading to the setting and approval of detailed income and expenditure budgets on a service-by-service basis, including in relation to the delivery of social services and social care. In doing so, the local authority will set its council tax demand, considering the revenue it receives from other sources, and its proposed expenditure. It is then the responsibility of the full council, on the recommendation of its executive, to approve the budget. The detail of the processes by which local authorities allocate funding to the services for which they are responsible is a matter for the local authorities, and not something I am able to comment upon.

104. The Welsh Government gathers and publishes annually a statistical bulletin which summarises local authority expenditure for the financial year in question. The table below sets out, for each financial year which falls wholly or partly within the specified period, the total revenue expenditure by the 22 local authorities, and the revenue expenditure on social services. I also exhibit the statistical bulletins from which these figures are sourced.

Financial year	**Total local authority revenue**	**Local authority revenue expenditure**	**Exhibited statistical release**

	expenditure (£ million)	on social services (£ million)	
2019-20	7,368.4	2,032.2	**(AH2/020-INQ000492880)**
2020-21	8,118.7	2,291.2	**(AH2/021-INQ000492881)**
2021-22	8,472.3	2422.5	**(AH2/022-INQ000492882)**
2022-23	8,892.3	2610.8	**(AH2/023-INQ000492883)**

Eligibility for adults seeking help with social care

105. Under parts 3 and 4 of the Social Services and Well-being Act 2014 ('the 2014 Act'), local authorities have duties to assess and meet the needs of adults and children for care and support and carers for support, including both adult and child carers.

106. Part 3 (assessing needs) provides for the circumstances in which a local authority must assess a person's needs for care and support, or a carer's needs for support and for how assessments must be carried out. Specifically, Section 19 requires local authorities to assess whether an adult has care and support needs and if so, what those needs are. The duty is triggered where it appears to a local authority that an adult may have such needs. Section 24 requires a local authority to carry out an assessment of a carer's need for support. Again, the duty to assess is triggered if it appears to the local authority that a carer may have needs for support.

107. Part 4 (meeting needs) provides for the circumstances in which those identified needs for care and support, or support for carers, may or must be met by local authorities and for how needs are to be met. The 2014 Act is not prescriptive about how local authorities can meet the needs of adults, children and carers for care and/or support, but it does give (at section 34) examples of the ways needs can be met,

including by the local authority arranging for someone else to provide something or by providing something itself. Section 34 also gives examples of what may be provided or arranged to meet needs, including accommodation, care and support at home or in the community and payments (including direct payments). I exhibit at **AH2/024-INQ000496060** guidance published by the Welsh Government, which describes in more detail the duties of local authorities in relation to the provision of care and support for children and adults.

Care and Support (Eligibility) (Wales) Regulations 2015

108. Section 32 of the Social Services and Well-being Act 2014 ('the 2014 Act') provides that the duty to meet needs for care and support under Part 4 of the 2014 Act will arise where it has been determined that the needs meet the eligibility criteria set out in the Care and Support (Eligibility) (Wales) Regulations 2015 (the Eligibility Regulations), which were made on 24 July 2015 and came into force on 6 April 2016.

109. The Eligibility Regulations set out the test a local authority must apply to determine whether an individual with needs identified in an assessment under section 19, 21 or 24 of the 2014 Act is entitled to have those needs met by a local authority. The Eligibility Regulations set out the eligibility criteria for adults, children and carers, and in each case, there are four separate conditions which must all be met:

i. The first condition relates to the person's circumstances and is met if the need arises from the kind of circumstances which are specified in the Eligibility Regulations, for example physical or mental ill-health. The Eligibility Regulations specify different kinds of circumstances for adults, children and carers; the circumstances for adults are set out in regulation 3, and for carers in regulation 5. Regulation 6 states that a person is to be treated as being unable to meet a need if doing so causes them pain, anxiety or distress; risks their health or safety or that of another person; or would take significantly longer than would normally be expected.

ii. The second condition is met if the need relates to one or more of the outcomes specified in the Eligibility Regulations, for example the ability to carry out self-care or domestic routines. The Eligibility Regulations specify different outcomes for adults, children and carers.

iii. The third condition is met if the need is such that the person is not able to meet that need alone, with the care and support of others who are able or willing to provide that care and support; or with the assistance of services in the community. This condition is modified in the case of a child such that it is met if the need is one that neither the child, the child's parents or other persons in a parental role are able to meet either alone or together.

iv. The fourth condition is met if the person is unlikely to achieve one or more of their personal outcomes unless the local authority provides or arranges care and support to meet the need in accordance with a care and support plan or it enables the need to be met by making direct payments.

110. I exhibit at **AH2/025-INQ000496065** the Welsh Government's Code of Practice on the exercise of social services functions in relation to part 4 (Meeting needs) of the 2014 Act. The Code of Practice sets out the requirements relating to eligibility, care planning and direct payments which local authorities must act in accordance with, along with guidelines to which they must have regard.

Charging for social care, direct payments, and benefits entitlement

111. Part 5 of the Social Services and Well-being Act 2014 ('the 2014 Act') covers charging and financial assessment in relation to services provided or arranged by local authorities under the Act. Local authorities can impose a charge for providing or arranging the provision of care and support or support, but it can only charge for the costs the local authority incurs in meeting the needs for which the charge is made. Where a local authority has concluded that it will meet a person's needs for care and support, it must carry out a financial assessment of that person's resources. In light of that financial assessment, the local authority must then determine whether it is reasonably practicable for a person to pay its standard charge for the service and, if not, how much it is reasonably practicable for the person to pay (if anything).

112. I exhibit at **AH2/026-INQ000496064** the Welsh Government's Code of Practice on the exercise of functions in relation to Part 4 and 5 (Charging and Financial Assessment) of the 2014 Act. The purpose of the Code of Practice is to make charging by a local authority, where it occurs, consistent, fair and clearly understood. The overarching principle is that people who are asked to pay a charge must only be required to pay what they can afford. People who require care and support will be

entitled to financial support from their local authority in certain circumstances based on their financial means and some will be entitled to care and support at no charge. Local authorities must consider, when deciding whether to charge and setting the level of any charge, any contribution or reimbursement they require to be paid or made.

113. In accordance with the 2014 Act and Part 4 and 5 Code of Practice, local authorities must ensure there is information and advice about their charging, and charging policies available in appropriate formats, which take account of people's communication needs (in particular for those with a sensory impairment, learning disability or for whom English is not their first language). This is to ensure that individuals can understand why they are being charged and how such charges have been calculated. Local authorities should also make the person aware of the availability of independent financial information and advice.

The Care and Support (Financial Assessment) (Wales) Regulations 2015

114. The Care and Support (Financial Assessment) (Wales) Regulations 2015[5] (the Financial Assessment Regulations) set out the requirements of a financial assessment, determining a charge and providing a statement of this charge. In carrying out the financial assessment the local authority must follow the requirements within the Financial Assessment Regulations and Part 4 and 5 Code of Practice. A local authority must reassess a person's ability to meet the cost of any charges, contribution or reimbursement should their financial circumstances change. This is likely to occur at least on an annual basis due to revisions to levels of welfare benefits and state pensions but may occur more frequently according to individual circumstances.

115. Under the Financial Assessment Regulations there are some circumstances where a local authority is not required to undertake a financial assessment. These include where:

[5] These regulations have subsequently been amended by the Care and Support (Choice of Accommodation, Charging and Financial Assessment) (Miscellaneous Amendments) (Wales) Regulations 2017, the Care and Support (Charging) (Wales) (Amendment) Regulations 2018, the Care and Support (Charging) and (Financial Assessment) (Wales) (Miscellaneous Amendments) Regulations 2019, the Care and Support (Charging) (Wales) and Land Registration Rules (Miscellaneous Amendments) Regulations 2020, the Care and Support (Charging) (Wales) (Amendment) Regulations 2021, the Care and Support (Charging and Financial Assessment (Miscellaneous Amendments) Regulations 2022 and the Care and Support (Charging and (Financial Assessment) (Wales) (Miscellaneous Amendments) Regulations 2023

i. the local authority charges a flat rate charge for particular care and support (including for preventative services and assistance) and as such, carrying out a financial assessment would be disproportionate to the charge levied;

ii. the person declines to provide information and/or documentation reasonably required to undertake the assessment, or only provides partial information. In that case the authority can determine whether to charge, and the level of that charge, based on available information, if it considers that it has sufficient information to do so;

iii. the person is receiving care and support for which no charge can be made.

116. The Financial Assessment Regulations and the Code address the requirements around the treatment of capital and income in a financial assessment. In terms of capital, the person's capital is considered in the assessment unless it is subject to one of the disregards set out in the Regulations and Code. The main examples of capital considered are the value of property and savings a person holds. In assessing what a person can afford to pay; a local authority must take into account their income. However, to help encourage people to remain in or take up employment, with the benefits this has for a person's well-being, earnings from employment must be disregarded when working out how much the person can pay. While, in the main, income is treated the same whether a person is in a care home or in receipt of care and support in the community (whether receiving this arranged or provided by a local authority or via direct payments), there are some differences between the two as to how income is treated which are set out in Part 3 of the Financial Assessment Regulations and Part 4 and 5 Code of Practice.

The Care and Support (Charging) (Wales) Regulations 2015

117. The Care and Support (Charging) (Wales) Regulations 2015 (the Charging Regulations) set the financial limit known as the "capital limit". Capital limit exists for the purposes of the financial assessment and sets out at what point a person is entitled to access local authority financial support to meet their eligible needs. Those with capital assets at or below this limit can seek means-tested financial support from their local authority. This means that the local authority will undertake a financial assessment of the person's means and may make a charge for the care and support they are or will be receiving based on what the person can afford to pay towards the cost of providing or arranging this. When undertaking the financial assessment, capital

at or below the capital limit must be disregarded in the assessment of what a person can afford to pay. Where a person's capital is at, or below the capital limit, they must not be required to contribute to the cost of their care and support from their capital.

118. A person with more capital than the capital limit can ask their local authority to arrange their care and support for them if they choose. However, people in this position will be required to pay the full cost of their care and support in residential care, or the full cost up to the weekly maximum charge in relation to non-residential care and support, until such time as the value of their capital is at or below the level of the capital limit. It should be noted that a different capital limit may apply in relation to residential care and support and non-residential care and support.

119. In determining the amount of a charge, contribution or reimbursement, a local authority must follow the requirements of the Charging Regulations, which prescribe:

i. the persons who may not be charged;
ii. services for which a charge may not be made;
iii. the maximum weekly charge for non-residential care and support
iv. the capital limit; and
v. the minimum income amount for a person provided with non-residential care and support and for a person in receipt of care and support in a care home.

120. People in a care home with capital at or below the capital limit will contribute most of their income, excluding their earnings, towards the cost of their care and support. However, a local authority must leave the person with a specified amount of their own income so that the person has money to spend on personal items such as clothes and other items that are not part of their care and support. This is known as the minimum income amount (MIA). This is in addition to any income the person receives from their earnings. Local authorities have discretion to apply a higher minimum income amount in individual cases, for example where the person needs to contribute towards the cost of maintaining their former home. The Charging Regulations set the level of the minimum income amount which authorities must allow residents to retain. This level may change from time to time.

121. In determining the amount of a charge under section 59 of the 2014 Act, or of a contribution or reimbursement under sections 50-53 of the 2014 Act in connection with direct payments, local authorities must not charge a person in receipt of non-

residential care and support more than a weekly maximum charge for all the non-residential care and support they receive.

122. The Charging Regulations maintain this requirement and set the level of the maximum charge to which authorities must adhere. Local authorities are not at liberty to charge a non-residential care and support recipient more than this maximum charge in a week irrespective of the size and cost of the non-residential care package they have. This applies equally where a person receives dual services; i.e. care and support provided or arranged by their local authority and care and support provided through direct payments. The total of any charge made, or amount required, for both must not exceed the weekly maximum.

123. It is open to authorities to operate a lower maximum weekly charge than set in the Charging Regulations if they wish. The maximum weekly charge set in the Regulations is kept under review and may be revised.

The Care and Support (Direct Payments) (Wales) Regulations 2015

124. Direct payments are monetary amounts made available by local authorities to individuals, or their representative, to enable them to meet their care and support needs; or in the case of a carer, their support needs. Direct payments are a mechanism by which people can exercise choice, voice and control to decide how to meet their needs for care and support and achieve their personal outcomes.

125. Direct payments replace care and support provided directly, or commissioned by, a local authority. They can be for all, or part, of a person's care and support needs, in the latter case the remainder of their care and support needs being met in an alternative manner.

126. Under the 2014 Act local authorities have powers to provide direct payments under:

i. section 50 – to meet the care and support needs of an adult,
ii. section 51 – to meet the care and support needs of a child,
iii. section 52 – to meet the support needs of a carer.

127. In the provision of, and operation of direct payments, local authorities must follow the provisions of the relevant section of the 2014 Act. They must also follow the

Care and Support (Direct Payments) (Wales) Regulations 2015. In cases where the care and support plan identifies care and support which may require a financial contribution from the individual, arrangements must be made to ensure the individual is clear about this, and that a financial assessment, as I have described above, is undertaken, where this is required under Part 5 of the 2014 Act.

128. Under paragraph 130 of Schedule 7A to the Government of Wales Act 2006, social security schemes supported by public funds is a reserved matter. The schedule defines social security schemes as *"...schemes providing financial assistance for social security purposes to or in respect of individuals, including, in particular, providing such assistance to or in respect of individuals—(a) who qualify by reason of old age, survivorship, disability, sickness, incapacity, injury, unemployment, maternity or the care of children or others needing care; (b) who qualify by reason of low income, or (c) in relation to their housing costs."* As such, the UK Government is solely responsible for determining entitlement to benefits for those in receipt of or providing domiciliary care in Wales.

129. The UK Government website provides information on benefits and financial support for disabled people or those who have a health condition, and lists these benefits:

i. Employment and Support Allowance, which is available to people who have a disability or health condition that affects how much they can work;
ii. Personal Independence Payment, which can help with extra living costs for those who have a long-term physical or mental health condition or disability and have difficulty doing certain everyday tasks or getting around because of that condition;
iii. Attendance Allowance, which may be available to a person who has a physical or mental health condition or disability and is of State Pension age or older;
iv. Universal Credit, which is a payment to help those on a low income, out of work or unable to work with their living costs; a person who has a health condition or disability which limits how much work they can do may be entitled to a higher rate of Universal Credit.

130. There is also a range of benefits which may be available to people who have experienced work-related or armed forces-related injuries.

131. The UK Government website also provides information on benefits and financial support for those caring for someone, and lists these benefits:

i. Carer's Allowance, to which a person may be eligible if they care for someone for at least 35 hours per week and the person they are caring for is entitled to certain benefits,
ii. Carer's Credit, which is a National Insurance credit which may be available to a person if they are caring for someone for at least 20 hours per week,
iii. Universal Credit, which is a payment to help those on a low income, out of work or unable to work with their living costs,
iv. Pension Credit, which provides extra money for those on low income who are over State Penson age and can also help with housing costs.

Regulatory Regime for Social Care Services

132. The system for regulating adult and children's social care services in Wales is set out in the Regulation and Inspection of Social Care (Wales) Act 2016 (the 2016 Act). Part 1 of the Act covers the regulation of social care services, setting out the regulatory processes applying to a person who applies to, and subsequently delivers, a social care service in Wales which is regulated under the Act. It also provides detail in respect of the regulation of local authority social services functions. Section 2 of the 2016 Act lists the regulated services that are subject to regulation, and meaning of each entry in the list is set out in Schedule 1.

133. Part 2 of the 2016 Act makes provision for the registration of service providers. Part 2 includes provisions relating to:
i. the requirement for the registration of regulated services,
ii. the process by which a person may apply to the Welsh Ministers to become a service provider, for applications for a variation of service, provisions relating to the granting or refusal of registration or a variation of service,
iii. the duration of domiciliary support,
iv. considerations about the fit and proper person test,
v. the cancellation of registration (including the powers of Welsh Ministers)
vi. the issuing of improvement notices,
vii. the requirement for designation of a responsible person and the cancellation of that delegation,
viii. circumstances where urgent variation or cancellation of services or places may be required,

ix. the right to appeal against decisions of the Welsh Ministers.

134. In addition, Part 3 of the Act renamed the Care Council for Wales as Social Care Wales, the body with responsibility for the regulation of the social care workforce in Wales. Parts 4-8 of the Act cover matters including the registration of social workers, and the fitness of such workers to practise. The 2016 Act provides the basis for Care Inspectorate Wales to regulate services defined in Schedule 1 of the 2016 Act. As described above, the Welsh Ministers have regulatory functions under the 2016 Act, but these are carried out by Care Inspectorate Wales on a day-to-day basis in accordance with a Memorandum of Understanding. Under that Memorandum of Understanding, Care Inspectorate Wales registers, inspects, and takes action to improve the quality and safety of services for the well-being of the people of Wales. Care Inspectorate Wales decides who can provide services; inspects and drives improvement of regulated services and local authority social services; undertakes national reviews of social care services; takes action to ensure services meet legislative and regulatory requirements; and responds to concerns raised about social care and childcare services. I understand that the Inquiry has issued a request for information under Rule 9 of the Inquiry Rules to Care Inspectorate Wales, so I do not provide more detail about their functions or how they undertake them in this statement.

Pre-pandemic Planning

135. In terms of the Health and Social Services Group and my directorate, pre-pandemic planning was covered in detail as part of Module 1 to the Inquiry which addressed pre-pandemic preparedness. The information below is limited to adult social care and therefore the key workstreams, and groups in place immediately before the Covid-19 pandemic rather than detailing the evolution of emergency planning in Wales.

136. I did not lead on any of the work that took place before the Covid-19 pandemic that was relevant to general pandemic planning, including where this work touched on the potential impact of a pandemic on the adult social care sector. I have therefore been supported by Welsh Government officials to provide the necessary detail for the purposes of addressing these questions in this statement.

137. The pressures on social care during a flu pandemic have been identified throughout the pandemic planning process, in the form of Exercise Winter Willow 2007, which I exhibit as **AH2/027-INQ000128977**, and Exercise Taliesin in 2009, which I exhibit as **AH2/028-INQ000128976**. These pressures were further demonstrated during the Swine Flu pandemic and the recommendations made in the independent review of the UK response conducted by Dame Deirdre Hine (the Hine Review) which I exhibit at **AH2/029-INQ000035085**. This review led to the UK nations agreeing to the 2011 flu strategy exhibited as **AH2/030-INQ000102974**[6] which superseded the 2007 National Framework.

138. The Winter Willow Exercise in 2007, a UK level (Tier 1) pandemic flu exercise, identified the possible prioritisation of antiviral drugs, vaccines and antibiotics in the event that they are in short supply for frontline social care workers. Exercise Taliesin, a live exercise undertaken across Wales in 2009, identified that although considerable progress had been made in developing resilience within the social care sector during the response to swine flu, further work was required to enhance the engagement with, and preparedness in, the independent care sector. This followed the Welsh Government issuing a framework, Planning for Pandemic Influenza in Social Services (2008) which is described in exhibit **AH2/031-INQ000499590**, to assist local authorities, social services managers and others plan for an influenza pandemic.

139. The ensuing Hine review in 2010 identified the social care sector as an area of ongoing concern, particularly in relation to the independent sector and independent special schools. However, there was the need for more active involvement of Devolved Governments at an early stage; clearer guidance on excess deaths; involvement of faith communities and the voluntary sector at all levels; as well as antiviral distribution arrangements and the identification and treatment of the vulnerable.

140. Both the Hine review into the response to Swine Flu and later the Wales Lessons Identified Report, which I exhibit as **AH2/028-INQ000128976**, explained the risk of a more severe pandemic and that lessons should continue to be learned, and improvements made to avoid complacency within the sector.

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[6] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000116441]*

141. Although a great deal of activity occurred following Swine Flu in 2010, the outcome of Exercise Cygnus held in Wales in 2014 which I exhibit as **AH2/032-INQ000107136** still retained recurring themes within the social care sector from earlier exercises.

142. The Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance was subsequently issued in 2014 which I exhibit as **AH2/033-INQ000116503.** The guidance identified the risks involved in a flu pandemic and the impact it was likely to have on the sector in terms of increased demand for care, a reduction in staffing numbers, resident illness, excess death, transport problems, and reliance on community care to cope with the numbers needing to be discharged from hospitals or becoming vulnerable. Social care organisations were encouraged to maintain business continuity plans to respond to such challenges and to sustain fair and fast access to services for those most in need.

143. Advice was also given in the guidance to help health and social care organisations, such as health boards, Public Health Wales, NHS Trusts, local authorities and other partner agencies, including the voluntary sector and independent sector providers, on the prioritisation for referrals for assessment, remote or self-assessment for all but the most complex cases, deferral of non-essential cases and the re-deployment of staff to cover critical services. The meticulous use of infection control procedures, isolation and cohort nursing were regarded as fundamental in limiting the transmission of the virus. Regular risk assessments for required levels of infection control were seen as essential in communal living environments such as residential homes and social care environments. It was stressed that the highest levels of hand and respiratory hygiene needed to be maintained and Personal Protective Equipment, including surgical masks and respirators, were seen as having a role in protecting healthcare workers, provided they were used correctly, and in conjunction with hand hygiene and other infection control practices. Arrangements were also required for minimising the risk of transmission and infection during the pandemic by isolation or cohort-grouping of infected clients.

144. Care homes within the same local area were asked to consider collaboration and mutual support, e.g. by forming 'clusters', to enable each to be aware of local capacity, the kind of care available, and which care homes were taking new admissions, including those with flu. Organisations were also directed to the United Kingdom Homecare Association (UKHCA) guidance on domiciliary care.

145. All social care organisations were advised, as part of their business continuity planning, to gain a detailed understanding of the potential impact of a pandemic on the supply of consumables, medicines and other services that were critical to maintaining necessary services. As part of this process, they needed to ensure that their suppliers had their own business continuity plans in place that were resilient to the potential supply chain challenges they may face during a pandemic. Facilities, equipment, plans, protocols, and staff training needed to be regularly refreshed and tested to ensure that preparedness and business continuity was maintained between events.

146. Health and social care organisations were urged to work together by having plans in place that provided for a clear definition of responsibilities, reporting and collation of surveillance requirements, contact tracing, swabbing and testing of samples, issue of antivirals through all phases of the response, surge plans for primary, secondary and critical care, implementation of the National Pandemic Flu Service, implementation of a pandemic specific vaccination programme, and a plan for the recovery and return to business as usual, to ensure that their overall resources were used to best effect, that communication and key support to carers were provided, and that carers were given help to assess their own needs. They were encouraged to work with Local Resilience Forums to provide necessary support, where required, from other agencies and ensure communications were in place with independent sector providers on the impact on their services and any support required.

147. Exercise Cygnus in 2016 continued to identify a knowledge gap in community services preparedness, including both adult social care and community health care, as recognised in the post-Cygnus report produced by Public Health England which I exhibit as **AH2/034-INQ000128983**. The findings reinforced the conclusion that in any response to a pandemic it was important to understand adult social care capability and capacity and how this could be expanded to cope with increased demand in the light of reduced staffing numbers. It once again recognised the role that local authorities played in managing the adult social care systems and how they needed to work closely with the NHS, independent care sector, voluntary organisations and other sector partners in this capacity.

148. The Cygnus report contained two recommendations to address this issue:

a. A methodology for assessing social care capacity and surge capacity during a pandemic should be developed. This work should be conducted by the UK Department for Communities and Local Government, the Department of Health, and Directors of Adult Social Services, (DASS) and with colleagues in the Devolved Governments. (Lesson 18).

b. The possibility of expanding social care real estate and staffing capacity in the event of a worst-case scenario pandemic should be examined. (Lesson 19).

149. The UK Government established its Pandemic Flu Readiness Board to take forward the recommendations from Exercise Cygnus nationally. The Welsh Government was represented on the Board and had engaged in a number of its sub-groups, including Social Care for which Deputy Director Alistair Davey was the nominated Social Services and Integration Directorate representative.

150. In September 2017 the Welsh Government established a Wales Pandemic Flu Preparedness Group involving representation from Welsh Government Health, Social Services, Communications and Resilience teams, alongside Public Health Wales and the chairs of the four Wales Local Resilience Forum Pandemic Flu Groups. Alistair Davey represented the Social Services and Integration Directorate. The Group was responsible for taking forward the recommendations of the reports. The Group reported to the Wales Resilience Forum, chaired by the First Minister, on progress made. I exhibit the minutes of the meeting as **AH2/035-INQ000107112** which took place on 27 September 2017 and listed the agreed workstreams and summarised the current position of those workstreams. In terms of social care, it was identified that future work would be likely to include guidance on how to deal with increased pressure at a local, regional and national level on the adult social care system. During the following two years, the Group continued to work with the UK Pandemic Flu Readiness Board and the Local Resilience Forums to implement the Cygnus report recommendations in local and all-Wales plans. The work of the Group included engaging with the UK Government Pandemic Flu Readiness Board to:

- establish whether Wales's specific social care provisions were required in the draft Pandemic Flu Bill;
- undertake an initial review of the existing Welsh Health and Social Care Influenza Pandemic Preparedness and Response Guidance published in 2014 to ensure it properly reflected current policy and practice; and

- undertake an initial review of the draft UKG "Extreme Surge" guidance to consider its suitability to support partners across Wales respond to pandemic.

151. By way of an example, in July 2018 a project on social care surge in Wales during a flu pandemic was initiated. I exhibit the project initiation document as **AH2/036-INQ000187057**. The aim of the project was to consider the information and analysis emerging from the UK Government in respect of preparing for a surge in the social care sector, and where appropriate ensuring similar arrangements were made in Wales to reflect the structures in Wales, and also to ensure appropriate easements in legislation and regulation could be made available to support the sector during a pandemic. Progress was fed back to the Wales Pandemic Flu Preparedness Group and in turn the Readiness Board.

152. Before the pandemic, the Wales Pandemic Flu Readiness Group had last met on 5 November 2018. The Group was advised as part of that meeting that the UK Government review work had slowed due to Brexit being the priority, with a number of UK Government leads changing posts. However, in terms of the social care surge guidance, the group was advised that work had been done and the draft guidance would be circulated to the group for comment. Meetings of this group were then paused due to Brexit priorities. I exhibit the Extreme Surge Guidance for the NHS in Wales 2020 as **AH2/037-INQ000253848**[7]). This guidance was still in draft at the start of the pandemic and intended to be annexed to the Wales Health and Social Services Pandemic Planning and Response Guidance exhibited above. This guidance considered, among other things, the clinically vulnerable and discharge arrangements as well as potential need for local authorities to work with sector partners to assess individuals' risks based on vulnerability.

153. The Wales Pandemic Flu Readiness Group meetings were reconvened in early 2020. In preparation for the commencement of those meetings a paper dated 23 January 2020 was prepared, which outlined the role of the Pandemic Flu Readiness Board, and the action and activity in Wales at that time, and therefore provides a good snapshot of the position before the Covid-19 pandemic period. A copy of this paper is exhibited as **AH2/038-INQ000180621** and outlines how the Welsh Government

[7] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000421656]*

sought to engage health, social services and local government in the work of the UK Board and its sub-groups.

154. The expectation was that guidance documents prepared as part of the work of the Wales Flu Pandemic Preparedness Group relating the social care sector, such as surge capacity, would be amended to reflect any changed requirements in surge planning. Further, if necessary, clauses would be developed in respect of the proposed Pandemic Flu Bill and potential changes in regulatory processes to support the social care sector identified.

Planning in social care during the Covid-19 pandemic

155. At the start of the Covid-19 pandemic, Social Services and Integration Directorate set key objectives based on local intelligence gathering and discussions with relevant internal and external stakeholders. These objectives were to ensure:

a. The financial sustainability of the social care sector, including support for local authorities;
b. That vulnerable children and adults who are most at risk were safe, visible and linked into appropriate services and support;
c. The effective operation and adequate capacity of care and support at home, care homes, other residential care settings and supported accommodation, by easing regulatory requirements and ensuring the supply of medication and food; and
d. Sufficient social care workforce with access to emotional and practical support, including access to PPE and Covid-19 testing.

156. The Social Services and Integration Directorate introduced a range of emergency measures including the establishment of a Covid-19 Co-ordination Hub, a range of Covid-19 workstreams to respond urgently to the demands of the pandemic, and an online 'capacity tool' for care home service providers.

157. A Welsh Government Internal Audit Service report completed in December 2021, which I exhibit as **AH2/039-INQ000022606**, provided 'Reasonable Assurance' on the controls that the Social Services and Integration Directorate had put in place in response to the pandemic, with a few matters identified as requiring attention to strengthen and enhance existing controls. The actions taken to address these issues,

and their outcome were reported to and have been monitored by the Health and Social Services Group Audit and Risk Assurance Committee.

158. The report found that the 21 workstreams established within the Social Services and Integration Directorate to respond urgently to the demands of Covid-19 supported the achievement of key objectives and clearly identified connections and interdependencies between them. In particular, the Covid Hub was used to communicate important messages and guidance to all internal and external stakeholders and was seen as an effective tool in keeping stakeholders informed. It also provided a mechanism for social care sector leaders to share information on impacts and proposed solutions to aid sector resilience.

159. As with all guidance produced and actions taken during the pre-Covid-19 period, the work undertaken by the Welsh Government in the sector over the last 20 years has been based on what was known about the risk of a flu pandemic and the likely impact. The guidance produced was not designed for an emerging disease pandemic lasting more than two years, or with the level of impact experienced during Covid-19. The plans were made based on the known risk and were useful in providing a template for the response in the social care sector but could never provide the level of detail required for Covid-19.

160. Much of the Covid-19 response drew upon on the planning for a flu pandemic, but it required either adaptation or the development of totally new arrangements to meet the distinct, ever-changing challenges of Covid-19. Decisions taken in regard to the social care sector at the beginning of the pandemic were based on what was known about the emerging risk at that time, as I describe later in the statement. These decisions, in terms of discharging patients to residential care, isolation, the provision of PPE, the re-prioritisation of healthcare, and restrictions on visits, were all reviewed and revised as greater knowledge of the virus and its impact on the sector were acquired, which I address later in the statement.

161. I have been asked to briefly describe the Health and Social Services Group's involvement in the Coronavirus Action Plan; the Covid-19 preparedness and response: guidance for the health and social care system in Wales; and the Care Home Action Plan. I will address those plans in turn below; in doing so I have drawn on the evidence provided by Andrew Goodall for Module 3 (HSSG-01).

Coronavirus Action Plan

162. The UK Government Civil Contingencies Secretariat produced the initial draft of the Coronavirus Action plan which was shared with the Devolved Governments for comment on 27 February 2020 at 18:55pm and comments were requested by 10:30am on the 28 February 2020. The coordination of the response was led by health officials who submitted comments on behalf of the Welsh Government on 29 February 2020.

163. The Coronavirus Action Plan was subsequently published on 4 March 2020.

Covid-19 preparedness and response: guidance for the health and social care system in Wales

164. On 18 March 2020 the 'Covid-19 preparedness and response: guidance for the health and social care system in Wales' was issued by Health and Social Services's Planning and Response Group. This guidance was to be read in conjunction with other guidance, particularly the Wales Health and Social Care Influenza Pandemic Preparedness & Response Guidance 2014.

Care Home Action Plan and Professor John Bolton's rapid review of social care during the pandemic

165. The Care Home Action Plan was borne from Social Services and Integration Directorate's desire to draw together the experience from the first response to Covid-19, specifically to prepare for any further wave. I was also aware of the Older People's Commissioner for Wales's report, Care Home Voices – A Snapshot of life in care homes in Wales during Covid-19, exhibit **AH2/040-INQ000501532**, which called for the Welsh Government to publish an action plan for care homes, and I wanted to ensure that our response was not only comprehensive, but also aligned with the concerns and recommendations highlighted in the report. By taking these into account, we aimed to create an action plan that directly addressed the challenges faced by care homes during the pandemic. This involved strengthening infection control measures, improving communication and support for care home staff, and ensuring the wellbeing of residents. The plan sought to build resilience within the sector, ensuring that care homes were better equipped to handle subsequent waves of the virus and any future public health crises.

166. The draft Care Home Action Plan was submitted to the Deputy Minister for approval on 29 July 2020 **AH2/041-INQ000336946**. I exhibit the draft plan as **AH2/042-INQ000336943**; a Ministerial Written Statement as **AH2/043-INQ000502003**; and a letter to the sector as **AH2/044-INQ000501535**. The Deputy Minister was invited to agree the initial Care Homes Action Plan which set out the range of activity to be undertaken over the next two months to support the sector, and was asked to note that as the work progressed, further activity may be identified and incorporated and as such there was no intention to publish the draft action plan at that early stage.

167. The work on the Care Home Action Plan coincided with a rapid review of care homes' experiences during the pandemic. In June 2020, the Social Services and Integration Directorate commissioned an independent rapid review to understand what had worked well and what could be improved for the future, in respect to the way in which local authorities and health boards had worked together to support care homes in Wales between March and June 2020. I exhibit the Ministerial Advice MA/JM/2058/20 dated 26 June 2020 as **AH2/045-INQ000116631**. Professor John Bolton, a consultant in adult social care, was subsequently engaged to carry out this review. On 1 July 2020, I sent a letter to local authority Chief Executives, Directors of Social Services, and Chief Executives of health boards, inviting them to reflect on their experiences to date in supporting care homes during the pandemic and to submit written responses setting out key actions that they had taken and were intending to take, which would be considered by Professor Bolton: **AH2/046-INQ000499656**. The letter's recipients were also invited to participate in individual discussions with Professor Bolton and to produce a regional action plan for care homes by early September 2020.

168. Professor Bolton also engaged directly with the Older People's Commissioner as part of his review. I exhibit the email sent by the Social Services and Integration Directorate to the Older People's Commissioner on 1 July 2020 informing her of the review and inviting her participation as **AH2/047-INQ000500232**. I am aware that the Older People's Commissioner expressed her concern to the Deputy Minister, as recorded in the email thread between Social Services and Integration Directorate officials on 22 July 2020 which I exhibit as **AH2/048-INQ000499653**, that the questions forming part of the review did not sufficiently focus on what might have not have gone well during the crisis, instead focusing overtly on what was successful.

This was not our perception, and indeed my letter of 1 July 2020 specifically asked for a summary of each organisation's weaknesses and gaps, as well as strengths, during the initial response.

169. The rapid review was discussed at a meeting of the Social Care sub-group on 24 July 2020, which included representation from the Older People's Commissioner's office. I exhibit a briefing paper prepared in advance of the sub-group's meeting as **AH2/049-INQ000499655**. The briefing paper set out the position as of July 2020 and the next steps Professor Bolton would be taking.

170. On 24 September 2020, advice was submitted to the Deputy Minister for Health and Social Services, exhibited at **AH2/050-INQ000136818**, which provided a summary of the progress made on the initial Care Homes Action Plan, and a copy of the Rapid Review Report exhibited as **AH2/051-INQ000253708**, the publication of which the Deputy Minister was asked to agree. The key messages from Professor Bolton's report were that the health and care sectors needed to work in partnership with care home managers to ensure that:

a. Every care home had an effective Infection Control Plan in place.
b. Every care home had an effective plan for business continuity that included ensuring that there were staff available to meet residents' needs.
c. Every care home should be supported to ensure there were meaningful and helpful day to day activities for residents and that the wellbeing of both staff and residents were considered in all the decisions that were made, including helping residents to remain in touch with relatives and friends.
d. Every care home had the right protective equipment.
e. Every care home had access to tests for residents and staff to know who may have the virus.
f. Every care home had good access to primary health services including GPs.

171. As stated, the Ministerial Advice also included a document that summarised the progress made on the Care Home Action Plan, dated 30 September 2020 which I exhibit as **AH2/052-INQ000253707**. The document listed the actions, next steps and target dates for those actions to be completed. The actions included; an infection prevention and control checklist for the management of Covid-19 in care homes; the ongoing arrangements for testing care home residents and staff; the supply of PPE free to the social care sector, and that care home residents be supported to maintain contact with their friends and family.

172. A further update was provided in December 2020, **AH2/053-INQ000275895**, and again in March 2021. I exhibit the December Ministerial Advice as **AH2/054-INQ000136878**, with a final update provided on 22 March 2021, **AH2/055-INQ000235980** (Ministerial Advice) and **AH2/056-INQ000350310** (update). Both the December 2020 and March 2021 Ministerial Advice invited the Deputy Minister to publish the Care Home Action Plan on the Welsh Government website. The final update listed the wide range of achievements delivered as identified in the Care Homes Action Plan over the previous 12 months. Specific examples listed in the advice included: an infection prevention and control checklist for the management of Covid-19 in care homes, supported by a webinar for care home providers; the successful roll-out of the vaccination programme to care home staff and residents; the introduction of enhanced Statutory Sick Pay for care workers, ancillary staff and agency staff who were unable to work due to Covid-19; the engagement with older people, younger adults and children who live in care homes to ask them about their experience during the pandemic and, in particular, what supported their well-being during that time; pilot programmes for use of visitor pods and visitor testing; and the sustained financial support through the Local Government Hardship Fund.

Overarching recovery plan: 'Health and Social Care in Wales - Covid 19 Looking forward

173. The development of 'Health and Social Care in Wales – Covid-19 Looking forward' was undertaken in the context of wider Welsh Government recovery planning. Members of the Health and Social Services Group contributed to the broader recovery plans of the Welsh Government, principally through the Continuity and Recovery Board that was established by the Welsh Government and which I referred to at paragraph 61 of this statement. As noted above, I sat on this Board as the representative of Social Services and Integration Directorate.

174. The Board, chaired by Jeremy Miles MS, Counsel General and Minister for European Transition, considered the complex and cross-cutting issues that arose as Wales emerged from the first wave of the Covid-19 pandemic and prepared for the end of the UK/EU Transition period.

175. Within the Health and Social Services Group, both the Health and Social Services Planning and Response Group and the Stabilisation and Reconstruction Scoping Board were responsible for the development, implementation and assessment of recovery plans specific to health and social care arising out of the

pandemic, as I have referred to at paragraphs 62 to 64 of this statement. The Health and Social Services Stabilisation and Reconstruction Scoping Board was established to focus on the integrated health and social care response to Covid-19.

176. To complement the Health and Social Services Stabilisation and Reconstruction Scoping Board, the Social Services and Integration Directorate also established a Social Care Stabilisation and Reconstruction Board, again as described at paragraphs 62-64 above. These Stabilisation and Reconstruction Boards oversaw the production of the 'Health and Social Care in Wales – Covid-19: Looking forward' plan published on 22 March 2021, which I exhibit as **AH2/014-INQ000066129**. This was followed by a specific framework for social care on 22 July 2021, entitled 'Improving Health and Social Care in Wales – Covid-19: Looking forward – Social Care Recovery Framework'.

Pre-pandemic adult social care provision in Wales

177. I have been asked to provide a breakdown of the adult social care provision in Wales including nursing and residential homes at the start of the pandemic or the nearest accounting period. I have been assisted by officials in Care Inspectorate Wales to provide the table set out below.

178. The data has been broken down to 'provider types' and sub-types to reflect the legal entities eligible to register a care home service with Care Inspectorate Wales. Please note services categorised under 'body corporate' may include services commonly referred to as 'not-for-profit'. However, it is important to note that Care Inspectorate Wales does not specifically categorise services as 'not-for-profit' and as such, I have been unable to denote those services.

Adult Care homes as at 1 April 2020 by Provider Type and Sub-Type

Service provider type	Service provider sub-type	Adults With Nursing	Adults Without Nursing	Domiciliary Support Service	Total
Body Corporate	Charitable Company	12	51	90	151
	Charitable Incorporated Organisation		1	1	2
	Charitable Trust		1		1
	Limited Company	226	534	384	1142
	Limited Liability Partnership	2	4		6
	Other Corporate Body	12	24	13	49
Body Corporate Total		**252**	**615**	**488**	**1355**
Individual Provider	Individual Provider	5	43	9	57
Local Authority	Local Authority		96	22	118
Local Health Board	Local Health Board		1	1	2
Partnership	Partnership	6	32	5	43
Unincorporated Body	Charitable Trust		3	1	4
Total		**263**	**790**	**526**	**1579**

Pre-pandemic service capacity within the adult social care sector prior to COVID-19

179. I have been asked in the Rule 9 request to provide an overview of the service capacity within the adult social care sector prior to the Covid-19 pandemic. The data can be found on the Stats Wales website[8] but requires some manipulation to obtain the figures shown in this section. For ease, I have broken down the relevant elements of the data below.

180. The figure below demonstrates that there were 75,741 adults in receipt of care and support services as of 31 March 2019:

[88] Adults receiving services by local authority and age group (gov.wales)

Data item (Total number of adults supported (count) ⓘ) | Year ⓘ (* 2018-19)

Data item | Area Code | Year ⓘ

Age Range

Local Authority ⓘ	Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
⊟ Wales	1,924	16,939	9,854	19,336	27,688	56,878	75,741

181. The illustration below highlights the total volume of services, meaning the overall total of the different types of social care services being provided (such as domiciliary support services, supported accommodation services, and so on, as further detailed below) as 125,415 as of 31 March 2019:

Data item (Total of services (volume)) | Year ⓘ (* 2018-19)

Data item | Area Code | Year ⓘ

Age Range

Local Authority ⓘ	Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
⊟ Wales	3,060	27,770	16,435	32,388	45,762	94,585	125,415

182. The below figures have been broken down into relevant service types.

a. Domiciliary support services

Data item (Domiciliary care) | Year ⓘ (* 2018-19)

Data item | Area Code | Year ⓘ

Age Range

Local Authority ⓘ	Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
⊟ Wales	317	4,577	3,787	8,047	11,868	23,702	28,596

b. Supported accommodation

Data item (Supported Accommodation) | Year ⓘ (* 2018-19)

Data item | Area Code | Year ⓘ

Age Range

Local Authority ⓘ	Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
⊟ Wales	216	2,433	510	270	227	1,007	3,656

c. Adult placement

Data item (Adult Placements) | Year (2018-19)

Data item | Area Code | Year

Local Authority	Age Range: Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
Wales	93	311	60	37	35	132	536

d. Adult care home (without nursing)

Data item (Adult care home (without nursing)) | Year (2018-19)

Data item | Area Code | Year

Local Authority	Age Range: Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
Wales	200	1,596	1,082	3,045	6,483	10,610	12,406

e. Adult care home (with nursing)

Data item (Adult care homes with nursing) | Year (2018-19)

Data item | Area Code | Year

Local Authority	Age Range: Total aged 18-24	Total aged 25-64	Total aged 65-74	Total aged 75-84	Total aged 85+	Total aged 65+	Total aged 18+
Wales	0	290	731	1,813	2,990	5,534	5,824

183. Data available on the Stats Wales website[9], shows the number of social care services and places regulated by Care Inspectorate Wales, by setting type and year. The illustration below shows the total number of settings and placements in relation to adult care home services as of 31 March 2019:

None

Drop Filter Fields Here

Setting	Financial Year: Mar-2019 Total Settings	Mar-2019 Number of Places
Total - All Categories	5,946	112,075
Total - Adult and Children Service	1,873	28,645
Residential Services	1,284	28,645
Adult Care Home Services	1,080	26,035

[9] CIW Services and Places by Setting Type and Year (gov.wales)

184. I understand that the Inquiry is particularly interested to understand the demographics of the data that is set out above, including the protected characteristics and any other vulnerabilities of those individuals in receipt of the different types of care that I have outlined. I have been informed that this information does not exist and was not held by the Welsh Government, or Care Inspectorate Wales, at the relevant time. I understand that the Welsh Government's Knowledge and Analytical Services is providing a witness statement to the Inquiry regarding the nature of the data on adult social care that was held.

Pre-pandemic workforce capacity within adult social care prior to COVID-19

185. I have also been asked to provide an overview of the workforce capacity within the adult social care sector prior to the pandemic. This information is also available on the Stats Wales website[10].

186. The illustration below highlights the total number of local authority staff working within domiciliary support for adults as being 4,101 as of 31 March 2019.

Staff ⓘ (Total staff at 31 March) | Year (2018-19)

Area code | Staff ⓘ | Year

Local authority	Post title	Total staff (STF)						
		Total Central management and support, social work and domiciliary services (STF1)						Total Central management and support, social work and domiciliary services (STF1)
		Total central management and support services (CMSS)	Total social work services for adults (SWSA) ⓘ	Total social work services for children and young people (SWSCYP) ⓘ	Total hospital/clinic settings (H/CS)	Total domiciliary services for adults (DSA)	Total domiciliary services for children (DSC)	
Wales		2,533	3,106	3,916	165	4,101	216	14,037

[10] Staff of local authority social services departments by local authority and post title (2014-15 onwards) (gov.wales)

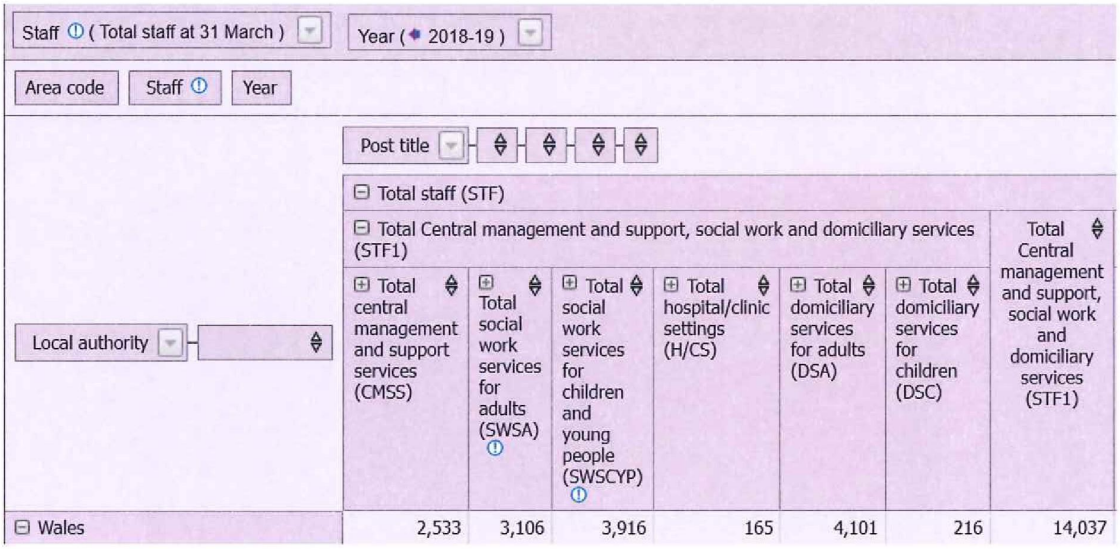
187. The figure below illustrates those local authority staff employed in residential services for elderly and mentally infirm people was 3,041, and the total number of those employed in residential services for adults with learning disabilities was 543.

⊟ Total residential services (STF2)						Total residential services (STF2)
⊞ Total residential services for elderly and elderly mentally infirm people (RSEEMIP)	⊞ Total residential services for adults with physical or sensory disabilities (RSAPSD)	⊞ Total residential services for adults with learning disabilities (RSALD)	⊞ Total residential services for adults with mental health problems (RSAMHP)	⊞ Total residential services for children and young people (RSCYP)	⊞ Total residential family centres	
3,041	30	543	44	524	0	4,182

188. The illustration below provides the breakdown of those employed in day /community provisions.

⊟ Total Day/community services (STF3)					Total Day/community services (STF3)
⊞ Total Day/Community Services for elderly and elderly mentally infirm people (D/CSEEMIP)	⊞ Total Day/Community Services for adults with physical and sensory disabilities (D/CSAPSD)	⊞ Total Day/Community Services for adults with learning disabilities (D/CSALD)	⊞ Total Day/Community Services for adults with mental health problems (D/CSAMHP)	⊞ Total Day/Community Services for children and families - family care centres (D/CSCFFCS)	
432	228	1,572	224	396	2,852

189. The figure below shows the total number of staff employed to provide social work services for adults was 3,106.



Staff ⓘ (Total staff at 31 March)	Year (2018-19)						
Area code / Staff ⓘ / Year							
	Post title						
	Total staff (STF)						
	Total Central management and support, social work and domiciliary services (STF1)						Total Central management and support, social work and domiciliary services (STF1)
Local authority	Total central management and support services (CMSS)	Total social work services for adults (SWSA) ⓘ	Total social work services for children and young people (SWSCYP) ⓘ	Total hospital/clinic settings (H/CS)	Total domiciliary services for adults (DSA)	Total domiciliary services for children (DSC)	
Wales	2,533	3,106	3,916	165	4,101	216	14,037

190. Social Care Wales has also produced a number of factsheets which offer key points and trends in terms of social care workers, adult care home managers and domiciliary care workers.

191. In 2019 the factsheet on social care workers which I exhibit as **AH057-INQ000501718** illustrates that 6,293 social workers were registered with Social Care Wales.

192. As of 1 April 2020, the number of adult care home managers registered with Social Care Wales was 1,294, and the number of domiciliary care managers on the register was 913. I exhibit both factsheets as **AH2/058-INQ000501716** and **AH2/059-INQ000501717**.

Decision making during the pandemic

193. Officials across the Social Services and Integration Directorate engage with Ministers via meetings and email. The formal method of advising is via the Ministerial Advice process which provides a channel for ministers to make decisions relevant to their portfolio which do not require a Cabinet collective discussion or decision. A Ministerial Advice (MA) document is submitted to relevant ministers to provide them with information, advice and options, to enable them to make a Ministerial decision. A Ministerial Advice is submitted to ministers when providing formal advice relating to a

new decision, relating to policy, operations, legislation or such other matter upon which a Minister is invited to make a decision. Each Ministerial Advice is allocated an MA number obtained from the Ministerial Advice Tracking System.

194. A Ministerial Advice should set out how the topic it addresses contributes to the delivery of the Programme for Government and the well-being objectives of the Welsh Government. In respect of particularly complex or controversial decisions, engagement with Private Office, Special Advisers or the Minister would take place in advance of submitting a Ministerial Advice. Ministerial Advice documents are cleared by a senior official before submission. A Decision Report is published on the Welsh Government's website for all Ministerial Advice where a Minister has taken a substantive decision. A Decision Report is a short summary of the issue and the Minister's response to a recommendation.

195. This approach to decision-making in the Welsh Government remained largely unchanged during the pandemic; the main exception would be the requirement for funding proposals to be considered by the Star Chamber before being submitted to Ministers. The Star Chamber was a forum established by the First Minister and chaired by the Minister for Finance and Trefnydd, to assess proposals for the allocation of resources to tackle the impact of the pandemic, and to act in an advisory capacity to the Minister for Finance and Trefnydd in relation to the deployment of available resources held centrally to address the challenges of the Covid-19 crisis.

196. An important element of decision-making during the pandemic was the 21-day reviews of the Coronavirus Regulations, which were the means by which non-pharmaceutical interventions (NPIs) to combat the virus were considered by Ministers, and then imposed, varied or removed. The implementation of non-pharmaceutical interventions had an impact on every Ministerial portfolio to some degree, and in some cases a very significant impact. It followed that decisions regarding the imposition and removal of non-pharmaceutical interventions should be taken collectively by the Cabinet. Cabinet often discussed a range of options and agreed an appropriate course. Those decisions were formally recorded and published as part of the Cabinet meetings minutes, provided to the Inquiry in Module 2B. Those decisions were then codified along with the necessary regulatory changes in Ministerial Advice submitted to the First Minister, or in his absence, the Minister for Health and Social Services. I did not routinely attend Cabinet but received feedback on the discussions from colleagues who did, such as Andrew Goodall, who attended as Director General. I am

asked to provide a chronology of the 21-day review process, together with a summary of its relevance to adult social care: I exhibit at **AH2/060-INQ000066076** a chronology of the key developments in respect of non-pharmaceutical interventions which I understand was prepared for Module 2B of the Inquiry, and at **AH2/061-INQ000500354** a summary of 21-day reviews which impacted upon social care. I also exhibit a list of the published Equality Impact Assessments that are relevant to decisions made regarding the adult social care sector: **AH2/062-INQ000500352.**

197. I am asked to explain whether the Public Sector Equality Duty was considered as part of the key decisions relating to adult social care that were made during the pandemic. I address those key decisions by topic, later in this statement. The Public Sector Equality Duty, which was introduced by the Equality Act 2010, aims to ensure that the public bodies that are subject to it consider the advancement of equality when carrying out their day-to-day business. It is supplemented by the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011, which contain certain specific duties that must be carried out as part of the general public equality sector duty. For example, those public bodies are required to publish equality objectives together with equality impact assessments, engagement requirements, progress reports, collection of data and more. The public bodies subject to the specific duties include the First Minister, the Welsh Ministers and the Counsel General to the Welsh Government, local health boards and NHS Trusts, Community Health Councils, County and County Borough Councils.

198. Within the Welsh Government, since July 2018 the standard tool used to assess equality impact is the Equality Impact Assessment (EIA). The Equality Impact Assessment forms one part of the Integrated Impact Assessment (IIA), which brings together all impact assessments into one comprehensive document (the other impact assessments that may be needed for certain decisions include, for example, an impact assessment on data protection). The Integrated Impact Assessment requires consideration of how the policy proposal is consistent with the Welsh Government's priorities, and how it contributes to the social, cultural, economic and environmental well-being of Wales.

199. Generally, during the pandemic, Equality Impact Assessments were undertaken in respect of the restrictions imposed in Wales, and in respect of key decisions, including decisions relating to the adult social care sector. However, due to the urgency of the situation and exponential increases in Covid-19 transmission,

decisions at the start of the Covid-19 pandemic were often made without a formal assessment of the impact, or were made in advance of a formal assessment being undertaken. A list of the published Equality Impact Assessments that are relevant to decisions made relating to the adult social care sector is exhibited at paragraph 196 above, and I indicate, in relation to the specific key decisions that are addressed in this statement, where a formal Equality Impact Assessment was carried out.

200. As to the Public Sector Equality Duty in the context of decisions on adult social care specifically during the pandemic, the Social Services and Integration Directorate took into account the duty in several ways, including by carrying out Equality Impact Assessments, as just described, to evaluate how policies would affect various groups, particularly those with protected characteristics. This included a focus on the needs of older people, disabled individuals and minority communities. Guidance was also provided to local authorities and care providers, emphasising the importance of considering equality issues in service delivery – for example in the care homes visiting guidance, which included an ethical framework for decision making; I describe the visiting guidance later in my statement. This guidance aimed to ensure that vulnerable populations had access to care and that specific challenges they faced during the pandemic were addressed.

201. Efforts were also made to engage with community groups and stakeholders representing diverse populations, ensuring that the voices of those affected by social care policies were included in decision-making processes. The Social Services and Integration Directorate also encouraged flexible approaches to service delivery, allowing for adaptations in care to meet the unique needs of individuals and ensure continuity of care – again the visiting guidance is an example of where we emphasised the need for flexibility in decision making about visits to care homes. Overall, we aimed to embed principles of equality and inclusivity in the response to the challenges faced in the adult social care sector at this unprecedented time, though we did not prioritise the practice of written impact assessments over the urgency of responding to the threat and risk of harm from the pandemic.

Developing understanding of the risks posed by Covid-19

202. I am asked to summarise the Health and Social Services Group's developing understanding of the risks posed by Covid-19, and in particular the risk of asymptomatic transmission and transmission rates generally, with reference to the

adult social care sector. As I explained earlier in this statement, it was the Social Services and Integration Directorate that had responsibility within Health and Social Services Group for social care policy and the social care aspects of the Welsh Government's response to the pandemic, and I therefore address this question by reference to Social Services and Integration Directorate's developing understanding specifically, rather than the broader Group. I am not able to comment on the developing understanding of asymptomatic transmission, or any other aspect of the virus, in any other part of the Group and I understand that this has been addressed in statements provided to the Inquiry in relation to other Modules. My role was to bring to bear my professional expertise, experience and knowledge of the social care sector, to assist understanding of what would be the practical consequences for the sector of the emerging science and its implications for how the spread of the virus could be combatted, and where necessary to provide challenge from my professional and policy perspective: not to the science itself, but about the implications of particular proposed courses of action for the care sector. I will provide examples of this later in my statement.

203. During the Covid-19 pandemic, decision-making within the Social Services and Integration Directorate was a multifaceted process involving a blend of verbal discussions and formalised meetings. This collaborative approach included policy officials, subject matter experts, and clinical advisers who worked together to address the evolving challenges. Verbal discussions allowed for rapid response and real-time problem-solving, while structured meetings ensured deliberation and integration of expert guidance. This hybrid strategy facilitated the development of informed, timely, and effective policies to manage the public health crisis.

204. The developing scientific understanding of Covid-19 was a matter for the relevant subject experts, such as Rob Orford (the Chief Scientific Advisor for Health, and co-chair of the Technical Advisory Group with Fliss Bennee) and Frank Atherton (Chief Medical Officer Wales) and Chris Jones (Deputy Chief Medical Officer Wales), all of whom were part of the wider Health and Social Services Group, as well as Public Health Wales. The Chief Scientific Adviser for Health also attended the UK Scientific Advisory Group for Emergencies (SAGE) and acted as chair of the Welsh Government's Technical Advisory Group. SAGE and the Technical Advisory Group were both key sources of advice and information for the Welsh Government in understanding the risks of the virus, which also had the benefit of reflecting the views of a range of experts across different fields.

205. I understand that the Technical Advisory Cell produced a regular 'TAC summary' which issued on a weekly and later a fortnightly basis, but to the best of my recollection I was not on the regular circulation list for these summaries, and did not routinely receive them. I am now aware that they were published online after they had been circulated internally. These summaries were sometimes referred to as the 'TAC CMO briefing' and helped to inform the advice provided by the Chief Medical Officer and his team.

206. The exception to this is that I was a recipient of advice and updates from the Technical Advisory Group and Technical Advisory Cell where the subject related to care homes: for example, I exhibit the covering email on 17 July 2020 for a report on care home discharges and deaths in care homes in the Aneurin Bevan Health Board area, at **AH2/063-INQ000499652** and the report at **AH2/064-INQ000385290**.

207. In addition, the Senior Medical Officer in the Health and Social Services Group's Public Health Division, Dr Marion Lyons, played a pivotal role in bridging health expertise and social care policy. Dr Lyons chaired the Outbreaks and Incidents sub-group of the Welsh Government's Health Protection Advisory Group (which was tasked with monitoring transmission rates and localised outbreaks, ensuring that decisions were based on the latest epidemiological data). Dr Lyons provided regular advice and updates to the Social Services and Integration Directorate on infection rates and transmission risks. She acted as the conduit for information for the Technical Advisory Group and Technical Advisory Cell, ensuring that policies were based on the latest scientific evidence and epidemiological data.

208. The Social Services and Integration Directorate, as well as the wider Health and Social Services Group, also regularly sought input directly from the Chief Medical Officer or Chief Scientific Officers' teams, or from Public Health Wales. An example of this is the production of guidance relating to the discharge of vulnerable residents from hospitals into care homes, on which Public Health Wales, Social Services and Integration Directorate officials, and other external sector representatives engaged closely, with oversight from the Chief Medical Officer, as I address in more detail later in this statement. The Chief Medical Officer and I also regularly communicated jointly to the care sector offering advice and guidance and informing them of policy changes, which I also address later in this statement. SAGE and Technical Advisory Group advice and updates would also influence decision making, as can be seen later in the section on hospital discharge for example. My directorate was reliant on subject

experts' and advisors' understanding of the risks posed by Covid-19, including the risks of asymptomatic transmission and transmission routes generally, and ensured regular engagement on the development of policy or in the formulation of formal advice to Ministers.

Decisions relating to the funding of the adult social care sector during the pandemic

209. As I have set out earlier, the Welsh Government does not directly fund adult social care. The statutory responsibility to fund and deliver adult social care rests with local authorities and funding is from a variety of sources, as I have described at paragraphs 92 to 131, including the Revenue Support Grant. The Revenue Support Grant is un-hypothecated, meaning that the decisions on how funding is utilised sit solely with local government. I have described these general, non-hypothecated funding arrangements for local authorities earlier in my statement. I have also set out the funding provided to support the integration of health and social care.

210. I describe below the major funding decisions made during the pandemic as they relate to adult social care. In doing so I should clarify that although Module 6 is examining adult social care specifically, the Welsh Government typically considers funding for social care holistically, rather than separately in terms of children's social care or adult social care, unless the issues are clearly relevant only to one or the other.

Support for the social care sector

Local Authority Covid Hardship Grant

211. To provide the information below about the establishment of the Local Authority Covid-19 Hardship Grant, I have relied upon evidence provided to Module 2B of the Inquiry by Reg Kilpatrick, who was the Director General for Covid Coordination and Director of the Welsh Government's Local Government Directorate. Through their regular communication with the Welsh Government from the outset of the pandemic, local authorities quickly raised concerns about the financial impact of Covid-19 and the accompanying restrictions on both the costs of the services that local authorities were required to provide, and the impact on local authority income, including council tax. For example, authorities suddenly lost income from a range of sources such as

car parking, leisure centres, and other charged services which they operated. Additional costs were also incurred for new activities such as enhanced cleaning, hygiene equipment, social distancing measures, increased enforcement, and increased activity on free school meals and tackling homelessness.

212. A Local Authority Covid-19 Hardship Grant (the Hardship Grant) was established to give special financial assistance to local authorities with additional expenditure incurred or revenue lost because of the pandemic. I was not directly involved in the establishment of the Hardship Grant, which was taken forward by the Welsh Government's Finance Policy and Sustainability Division. This Division was part of the Local Government Directorate. I understand that the Hardship Grant was set up in April 2020 following the provision of advice under reference MA/JJ/1027/20 to the Minister for Local Government and Housing (then Julie James MS) and the Minister for Finance and Trefnydd (then Rebecca Evans MS), dated 20 March 2020. I exhibit a copy of this advice as **AH2/065-INQ000227906**.

213. It was agreed that the Hardship Grant was to be a single grant and would operate as the principal route for additional funding for local government, to avoid the administrative overheads of having multiple funding streams covering each impacted area. Where local authorities required financial assistance for losses or expenditure relating to one of its service areas, this was achieved through the Hardship Grant, with decisions made on the basis of advice to those portfolio Ministers provided by their policy advisers. Ministers determined the amount of funding available within the Grant as the impacts of the pandemic became clearer. Operating the Hardship Grant as a single funding stream meant that there were no service-specific grant processes or terms and conditions and allowed funding to be managed within a single cover.

214. On 11 April 2020, my directorate submitted advice to the Minister for Housing and Local Government, the Deputy Minister for Health and Social Services, the Minister for Health and Social Services, and the Minister for Finance and Trefnydd, seeking agreement to an initial allocation of £40 million to local authorities to enable adult social care providers to meet additional costs arising from the Covid-19 outbreak: **AH2/066-INQ000136775**. These costs related mostly to maintaining care for existing service users, but the advice also noted the key role social care would play in hospital discharge. The funding was intended to cover an initial two-month period and would be distributed through a ring-fenced element of the Hardship Fund.

215. The allocation of £40 million was confirmed in a Written Statement issued on 17 April 2020 by the Minister for Health and Social Services and the Deputy Minister for Health and Social Services. I exhibit the statement at **AH2/067-INQ000493730**.

216. On 23 April 2020 the Minister for Health and Social Services approved a proposal for £10m to be allocated to support the system to enhance delivery of timely discharge of patients from acute and community hospitals to community settings including their home. Although linked to the £40 million allocation I have described above, this funding was not allocated through the Hardship Grant; rather the funding was to be allocated via the Regional Partnership Boards (the role of which I have addressed at paragraph 38 of this statement). The Ministerial Advice (MA/VG/1362/20) is exhibited as **AH2/068-INQ000215311**.[11]

217. On 16 June 2020, advice (MA/VG/1643/20) was submitted to Ministers setting out options for further funding support for adult social care providers. I exhibit the advice at **AH2/069-INQ000116594**. Ministers agreed to set a temporary standard national fee uplift, and that the Local Government Hardship Fund should remain as the mechanism for local authorities to claim the temporary standard national fee uplift. The fee uplifts were £50 per week for all local authority commissioned residential care; £75 per week for all NHS commissioned residential care (including nursing care) and jointly commissioned residential care; a corresponding increase of around £40 per week for all local authority commissioned supported accommodation; and £1 per hour of care for all local authority, NHS and jointly commissioned domiciliary care. Ministers confirmed the allocation of the further £22.7 million in a Written Statement issued on 3 August 2020 by the Minister for Health and Social Services and the Deputy Minister for Social Services. I exhibit the statement at **AH2/070-INQ000493732**.

218. The advice also outlined concerns about the financial viability of residential care homes because of the increase in voids (vacant places in a care home). This was due to Covid-19 related deaths within a setting, and also other factors, such as an inability to fill voids where homes were containing an outbreak, or the time taken to secure a test of a prospective resident to prevent an outbreak. Ministers therefore agreed that £7.550 million should also be allocated to address voids, to be distributed via quantum to each Regional Partnership Board rather than via the Hardship Fund.

[11] I can confirm, in response to the specific question asked in the Rule 9 request, that the £10 million to support hospital discharge described here is not covered in INQ000097622 and was not known as the Covid-19 Response Reserve.

219. On 29 June 2021, the Minister for Health and Social Services, the Minister for Finance and Local Government, and the Deputy Minister for Health and Social Services received advice (MA/JMSS/2041/21, exhibited at **AH2/071-INQ000116712**) in respect of further financial assistance to support the delivery of adult social care. This advice described proposals for next steps and a transition away from existing levels of subsidy during the second half of the financial year. These proposals were subsequently discussed with the Welsh Local Government Association, which agreed to the proposals in the Ministerial Advice, as per the email exchange exhibited at **AH2/072-INQ000493720.**

Recovery Fund for Social Care

220. On 29 July 2021, the Minister for Health and Social Services, the Minister for Finance and Local Government and the Deputy Minister for Social Services received advice (MA/JMSS/2607/21) seeking approval of a bid of up to £48 million from Covid-19 reserves to support a Social Care Recovery Fund. I exhibit the advice at **AH2/073-INQ000136861**.

221. The proposal had been developed by officials in my directorate in response to an invitation to develop schemes for one-year injections of funding, set out in a letter from the Minister for Finance and Local Government to her Cabinet colleagues, dated 2 June 2021, and exhibited at **AH2/074-INQ000493734**.

222. As set out in the advice exhibited above (MA/JMSS/2607/21), the proposal was for

i. an £8 million allocation for direct spending on specified social care Covid-19 recovery priorities/actions selected by the Welsh Government, and

ii. a £40 million allocation to local authorities to work with their partners and providers of service to ensure appropriate recovery in the priority areas set out in the Social Care Recovery Framework which had recently been published.

223. Ministers agreed the recommendations, and the Deputy Minister suggested there was little detail about how the £40 million would be allocated and asked me and members of my team to take on board some ideas which had been discussed in meetings with the leaders of two local authorities. I exhibit her response at **AH2/075-INQ000493725**.

224. Following further work by officials, the details of the Social Care Recovery Fund were subsequently announced on 14 September by the Deputy Minister for Social Services via a Written Statement, exhibited at **AH2/076-INQ000493733**.

225. The statement confirmed the £40 million recovery fund, as well as some specific recovery activities, including:

i. £1m to continue the Carers Support Fund, providing grants of up to £300 to unpaid carers in urgent need across Wales.

ii. £600,000 to support a cluster-level approach to the delivery of learning disability health checks, increasing health board activity in this area to support the health and wellbeing of individuals and to quickly identify potential health issues as early as possible and help reduce health inequalities.

iii. £100,000 to promote a rights-based approach for older people, commissioning work with older people and stakeholders to raise awareness of how to embed a rights-based approach in the design and delivery of relevant services.

iv. £190,000 to help improve the wellbeing offer for the social care workforce, to ensure they were supported during and after the pandemic. This funding recognised how critical the social care workforce was and the risks posed by staff shortages.

v. £140,000 for the Association of Directors of Social Services Cymru to support the delivery of the recovery framework through the coordination and delivery of national activities.

226. On 7 September 2021 the Minister for Health and Social Services, the Minister for Finance and Local Government and the Deputy Minister for Health and Social Services received advice about next steps for funding to support the delivery of adult social care in 2021-22 (MA/JMSS/3071/21, exhibited at **AH2/077-INQ000145145**). The advice also noted that domiciliary care services had come under significant pressure which was impacting on the flow of patients across the health and social care system, and Ministers were asked to maintain the £1 hour uplift on commissioned domiciliary care that had been agreed at the beginning of the pandemic. Ministers agreed the recommendations in the advice on 12 and 16 September 2021, exhibit **AH2/078-INQ000368997**.

227. On 11 October 2021, officials in my directorate submitted advice to the Minister for Health and Social Services, the Minister for Local Government and Finance and the Deputy Minister for Social Services, seeking agreement to an additional £42.7 million for a package of measures to address what the advice described as a crisis

situation. I exhibit the advice (MA/EM/3387/21) at **AH2/079-INQ000176883**. The health and social care system was continuing to experience ongoing impacts from the Covid-19 pandemic along with a range of other factors, contributing to high levels of escalation across the system. The advice noted that there was normally heightened demand for health and social care services during the autumn and winter periods, but at that point the situation in social care and health was already under significant pressure and demand continued to grow exponentially in comparison to capacity. This was impacting the ability of local authorities to provide support for the most vulnerable people in the community and appropriately discharge their statutory duty.

228. The Minister for Health and Social Services had established a Care Action Committee which she chaired, and which was attended by the Deputy Minister for Social Services and representatives from the NHS, local authorities, Welsh Local Government Association, the NHS Confederation, the Association of Directors of Social Services Cymru, Care Forum Wales, and the National Provider Forum, to identify immediate issues and agree solutions to prevent further deterioration. I exhibit at **AH2/080-INQ000498727** the note of the meeting on 30 September 2021, at which the proposals were discussed.

229. The proposals were set out in detail in an annex which included in the advice document exhibited above, and were summarised in a table which I reproduce below:

Proposal	**£m**
Integrated health and social care responses through Regional Partnership Boards including joint winter planning and support for micro enterprises	9.8
Additional Direct Payments to unpaid carers to avoid carer breakdown	5.5
Boost third sector carer's hardship funding to avoid carer breakdown	0.27
Third sector early intervention and prevention services	3.8
Children services	21.0
Advertising and promotional work to drive recruitment	0.35
Cluster based action	2.0
Total	**42.72**

230. The advice noted that if agreed, the measures would be deployed through funding directly to local authorities, to Regional Partnership Boards and to the third sector via a grants process, and through health board processes to GP Clusters. Ministers agreed these recommendations on 13 and 14 October 2021, email confirmation exhibited at **AH2/081-INQ000493726**.

Care Providers' healthcare costs

231. The Minister for Health and Social Services and the Minister for Finance and Trefnydd received advice (MA/VG/2390/20) on 29 July 2020 about a proposed NHS stabilisation fund. The advice was submitted by officials in the Finance section of the Health and Social Services Group and was copied to me: **AH2/082-INQ000361622**. The advice noted that Ministers had earmarked £100 million for the financial impact of Covid-19 on social care and agreed an initial allocation of £40m of this to meet the immediate costs adult social care providers were experiencing, along with an increase of £22.7m to cover the period up to September, as I describe above.

232. The advice noted that care home and domiciliary care providers were experiencing similar cost pressures in respect of NHS commissioned care (including nursing care) and packages of care jointly commissioned by local authorities and health boards, which had yet to be addressed at that stage. The Minister for Health and Social Services was therefore asked to agree that funding was allocated to local health boards to enable them to make a £75 per week national uplift for NHS commissioned residential care and jointly commissioned care packages, and an extra £1 an hour for the NHS commissioned domiciliary care. It was proposed that this funding would initially be allocated for the first six months of 2020-21, retrospective to April, at a cost of £22.4 million.

233. On 16 October 2020 further advice was submitted to the Minister for Housing and Local Government, the Minister for Health and Social Services, the Minister for Finance and Trefnydd, and the Deputy Minister for Health and Social Services in relation to the funding of the healthcare costs of care providers, reference MA/VG/3200/20: **AH2/083-INQ000235839**. That advice sought agreement to the allocation of a further £22.4 million for the period October 2020 to March 2021 to continue to support adult care providers with their Covid-19 costs in relation to healthcare. As part of that advice, Ministers also agreed to provide an additional £4.628 million to the Local Authority Hardship Fund, to cover the costs arising from

the earlier decision (MA/VG/1643/20, exhibited above) to extend the period for the funding until the end of June 2020.

Schemes to support social care workers

Special Payment Scheme for social care workers

234. The Special Payment Scheme for social care workers was established in recognition of the fact that the social care workforce was (and remains) at the frontline of delivering personal care to vulnerable people, and that the tasks they undertake involve a high level of often intimate personal care. During the pandemic, this meant that they were also having to accept a greater degree of risk and responsibility compared to workers in other sectors outside healthcare, whilst at the same time being amongst the lowest paid workers of any sector.

235. On 4 May 2020, the Minister for Health and Social Services, the Minister for Finance and Trefnydd and the Deputy Minister for Health and Social Services received advice, prepared by members of my team and cleared by me, setting out options for supporting the social care workforce. Providing additional support for this workforce was a challenging undertaking because of the complexity of the social care system, involving hundreds of employers, as emphasised in the advice, which also included detailed legal advice which covered, amongst other things, the duty on Welsh Ministers to exercise their powers in a way compliant with requirements not to discriminate unfairly deriving from the Public Sector Equality Duty. The Ministerial Advice document (MA/VG/1325/20, exhibited at **AH2/084-INQ000144869**), sets out these issues and complexities in detail, but in summary recommended that the Welsh Government should fund the delivery of a scheme that would provide a one-off supplement of £500 to social care staff. Further advice was provided on 5 June 2020 regarding the mechanics of the proposed scheme (MA/VG/1662/20, exhibited at **AH2/085-INQ000144895**).

236. The primary groups considered to fit the scheme parameters were domiciliary care workers, care workers in registered care homes, and managers/deputy managers of domiciliary care or care homes. Ministers were also recommended to include nurses - employed by care homes and all Personal Assistants.

237. Based upon an estimate of 64,600 eligible staff, the direct costs of which would be £2.3 million, Ministers had previously agreed to a budget allocation of £40 million for the supplement. Ministers agreed the recommendations, which were confirmed by the First Minister in a Written Statement issued on 11 June 2020, which I exhibit at **AH2/086-INQ000493731**.

238. Officials in my team provided further advice to ministers on 21 July 2020 (MA/VG02344/20, exhibited at **AH2/087-INQ000116598**), providing an update on the implementation of the scheme, and the development of guidance by officials and stakeholders. This guidance was subsequently published on 7 August 2020, and I exhibit it at **AH2/088-INQ000081223**.

239. On 29 January 2021, Ministers received advice (MA/VG/0179/21, exhibited at **AH2/089-INQ000350216**) that the forecast cost of the £500 scheme had increased to £45 million. The forecast £5 million overspend would be met from within the Health and Social Services Main Expenditure Group.

240. On 11 March 2021, the Minister for Health and Social Services received advice (MA/VG/0378/21, exhibited at **AH2/090-INQ000145062**) recommending a bonus payment of £500 for NHS staff and social care workers in recognition of their contribution and efforts during the pandemic, which the Minister approved: **AH2/091-INQ000368892**. I also exhibit related advice (MA/VG/1532/21) as to the eligibility criteria, which were to be wider than the previous scheme, at **AH2/092-INQ000235856**, and the Minister's approval on 16 April 2021 as **AH2/093-INQ000493718**. An Integrated Impact Assessment was undertaken in respect of the bonus payment; the full assessment is exhibited at **AH2/094-INQ000514870**, and the published summary is exhibited at **AH2/095-INQ000469871**.

Enhancements to Statutory Sick Pay for the Social Care Sector

241. Early in the pandemic, I recognised the significant financial challenges facing the social care workforce. With generally lower wages and fewer protections compared to NHS staff, many workers were at heightened risk of financial hardship. The sector's high staff turnover, coupled with increasing demand and financial pressures, underlined the fragile state in which social care was operating.

242. Understandably, this was also a matter of great concern to the Trade Unions, who from early in March 2020 were campaigning on the issue of workers who were not entitled to statutory sick pay. On 30 March 2020 the Minister for Health and Social Services received a letter from the GMB union: **AH2/096-INQ000180891**. The letter noted that social care staff who fell ill or were required to self-isolate were not protected by sick pay from their employers, meaning that they would receive only Statutory Sick Pay (SSP), which in March 2020 was £94.25 per week. This meant that many could not afford to take time off work. The GMB letter set out a range of demands, which included that social care should receive sick pay at the same rate as their full pay, underwritten by the Welsh Government if necessary.

243. The Deputy Minister for Health and Social Services responded to the GMB on 28 April 2020: **AH2/097-INQ000180892**. In relation to sick pay the Deputy Minister assured the GMB that the Welsh Government was examining how it could best improve the terms and conditions of the social care sector, considering all levers at its disposal.

244. The fundamental challenge for the Welsh Government in relation to this matter was that welfare benefits were and remain a fully reserved matter, for which responsibility is held by the UK Government. The Welsh Government did not have the powers or the infrastructure to make benefit-type payments to workers, nor was it funded to do so. Nonetheless, I recollect that Ministers were determined to explore ways in which we could help the sector.

245. On 18 May 2020, the UK Government announced that it would be providing £600 million, in part to avoid financially penalising any social care workers in England who needed to be off work because of the pandemic. The following day (19 May 2020) the Deputy Minister received a further letter from the GMB, referring to the UK Government's announcement and seeking to be involved in discussions about how its members in Wales would receive payments: **AH2/098-INQ000180893**. The Wales Trades Union Congress wrote on the same day, supporting the GMB's position: **AH2/099-INQ000180894**.

246. I did not attend the Star Chamber (a forum established by the First Minister to assess proposals for the allocation of resources to tackle the impact of the pandemic), but I understand that at its meeting on 5 June 2020, there was a discussion with the

Minister for Health and Social Services that touched on the recent UK Government commitments about sick pay for care workers and during which the Minister asked about consequentials for Wales. I exhibit the note of the meeting at **AH2/100-INQ000338573**.

247. On 8 July 2020, the Deputy Minister for Health and Social Services responded to the 18 May letter from the GMB union: **AH2/101-INQ000180895**. In her letter the Deputy Minister explained that although HM Treasury had indicated that because of the £600 million announcement, the Welsh Government could expect to receive a consequential amounting to £35 million, the actual amount would not be confirmed until much later in the year. The Minister also noted the important principle of devolution that funding is not ringfenced for any specific purpose, and that in the circumstances at the time, all consequentials received by the Welsh Government were added to the fund established to support public services and the economy. Potential measures to support the social care workforce would need to be considered in line with other priorities and in the context of wider pressures created by the Covid-19 response. Nonetheless, the Deputy Minister confirmed that she had asked officials to look at the costs of implementing in Wales a measure that would support the sector with Statutory Sick Pay.

248. On 24 August 2020, Ministerial Advice document MA/VG/2686/20, produced by members of my team, was submitted to the Deputy Minister for Health and Social Services, the Minister for Health and Social Services, and the Minister for Finance and Trefnydd: **AH2/102-INQ000495977**. The advice set out proposals for enhancements to Statutory Sick Pay for the social care sector, at a cost of £0.998 million per month, to top up Statutory Sick Pay to 100% for all workers within care home settings including ancillary staff; domiciliary care workers; and personal assistants, for a period of six months.

249. The Minister for Health and Social Services and the Deputy Minister for Health and Social Services agreed on 24 August 2020 the proposed eligibility details for the scheme, and the Minister for Finance and Trefnydd agreed in principle to an allocation of up to £6m in 2020-21 from the Covid-19 revenue response reserve to fund the proposed scheme for six months: **AH2/103-INQ000493712**. An Integrated Impact Assessment was undertaken in respect of the proposal, which is exhibited at **AH2/104-INQ000514868**.

250. Ministers received further advice on the development of the scheme on 16 October 2020, exhibited at **AH2/105-INQ000493711**. This recommended that the scheme should start on 1 November 2020 and end on 31 March 2021. It noted that the Statutory Sick Pay scheme was being introduced significantly later than in other parts of the UK, and that as a result, trade unions were very concerned that workers in Wales had been disadvantaged and felt strongly that payments should be backdated. However, given that the objective of the scheme was to influence care worker behaviour to improve infection control, it was suggested that there was limited rationale for making backdated payments. Moreover, there would be significant complexities in relation to tax and benefits. It was therefore recommended that payments were not backdated.

251. On costs, the advice provided projected costings, based upon a range of scenarios, of between £3.6m and £13.3m for the five months of the scheme. It further noted that as the revised upper cost projection exceeded the £6m previously agreed, further agreement would be required.

252. Ministers agreed the recommendations on 20 October 2020: **AH2/103-INQ000493712**.

253. Ministers received further advice on 3 December 2020 (MA/VG3953/20, exhibited at **AH2/106-INQ000145058**), which recommended the inclusion of workers in supported accommodation/ housing arrangements as eligible under the scheme, which Ministers agreed on 7 December 2020: **AH2/107-INQ000493713**.

254. On 2 March 2021 the Minister for Housing and Local Government, the Minister for Finance and Trefnydd, and the Deputy Minister for Health and Social Services received advice (MA/JM/0942/21, exhibited at **AH2/108-INQ000103973**) recommending that the enhanced Statutory Sick Pay scheme should be extended beyond the previously agreed end date of 31 March 2021. On costs, the advice noted that earlier projections had been for a range of £4.5 m - £16.7m, but claims submitted up to the end of January totalled £980,000. For the extension of the scheme, the advice noted that £3m had been allocated to the Hardship Fund for the extension of the scheme. Ministers agreed the recommendations on 3-4 March 2021: **AH2/109-INQ000493715.**

255. On 24 April 2020, advice (MA/VG/1389/20, exhibited at **AH2/110-INQ000361537**) was submitted to the Minister for Health and Social Services and the Minister for Finance and Trefnydd which referred to the intended Death in Service scheme for Covid-19 related deaths in the NHS and social care in England. This and other Ministerial advice documents relating to these matters was produced by colleagues within the Health and Social Services Group but outside my directorate. The advice proposed the development of a similar scheme in Wales funded from the Covid-19 reserve, and Ministers agreed for work to commence.

256. Further advice was submitted to Ministers on 22 May 2020 (MA/VG/1567/20, exhibited at **AH2/111-INQ000336604**) on the proposed NHS and Social Care Coronavirus Life Assurance Scheme (Wales) 2020, under which a payment of £60,000 would be made to the dependents of health and social care workers who died from work-related Covid-19. The advice confirmed that policy officials had given due regard to the Public Sector Equality Duty, that given the time allowed, a high-level assessment of the policy intentions of the scheme rules against the protected groups had been undertaken, and that an Equality Impact Assessment was be undertaken. I exhibit the Integrated Impact Assessment (which included the Equality Impact Assessment) at **AH2/112-INQ000221162**. The scheme was launched, and awareness raised via targeted communications to trade union bodies and the health and social care sectors.

257. Initially, the scheme was due to end on 25 March 2022 as this was when provisions of the Coronavirus Act 2020 were due to end. In advice to the Minister for Health and Social Services on 4 February 2022 (MA/EM/0446/22, exhibited at **AH2/113-INQ000493735**), officials asked for approval to extend the window for families to submit claims after the closing date of the scheme from 6 to 12 months. This was in line with the English scheme and was considered appropriate to ensure families did not miss the opportunity to claim. This was approved by Ministers.

258. A subsequent informal advice note was submitted to Ministers on 21 March 2022. At that time 37 claims had been received. Information on deaths of health and social care workers had been received from the Office of National Statistics (ONS), and although there were several caveats regarding the data, it indicated a potential

for a number of further applications for claims. It also indicated a decline in the frequency of deaths over time. Ministers were asked if they wished to allow the scheme to close on 25 March 2022, as previously set, or to extend until 30 June 2022. Ministers approved the recommendation of the advice to extend the scheme. This aligned with the end date of the Statutory Sick Pay Enhancement scheme which I have described above.

259. The scheme closed on 30 June 2022, with claimants originally having until 30 June 2023 to submit claims for deaths that occurred while the scheme was open. However, further Ministerial Advice was submitted on 6 June 2023 (MA/EM/1413/23, exhibited at **AH2/114-INQ000493738**) asking ministers to agree to extend the period for submission of claims for a further 3 months, until 30 September 2023. This was to give beneficiaries more time and was agreed. The English scheme also extended their closing date to this date.

260. Officials submitted an end of scheme report to Ministers on 25 October 2023. This report outlined efforts made to raise awareness of the scheme. As of 25 October 2023, the scheme in Wales had received 46 claims. This consisted of 30 claims relating to NHS staff and 16 claims relating to social care staff. At that time, 45 of these claims had been approved and total costs of the scheme were calculated at £2.7 million.

Support for carers

261. On 31 July 2020, officials in my directorate submitted to the Deputy Minister for Health and Social Services a draft Ministerial Advice document (**AH2/115-INQ000349756**) seeking approval for a proposed hardship fund for carers (which came to be known as the Carers Support Grant), which would then be reviewed by the Star Chamber (email exhibited at **AH2/116-INQ000349754**).

262. The background to this proposal was that a significant number of service users had reduced or handed back the care packages they received from social care services to protect themselves, or the person they cared for, from Covid-19. Since the start of the pandemic, many carers in Wales had been coping alone without the support of statutory services or their usual community and family networks, and the number of hours spent caring had increased. In addition, many were reporting financial hardship, as set out in the advice.

263. The proposal recommended to Ministers was for a Carers Support Grant of £1 million, which would provide approximately £45,000 financial assistance on average in each local authority. The fund could support 225 carers and their families in each local authority, assuming an average sum of £200 per carer, with 4,950 carers across Wales. These grants would be managed by the Carers Trust Wales, who had already put in place grant award processes to create their own Carers Emergency Fund.

264. The proposal was approved by Ministers on 13 October 2020, **AH2/117-INQ000144982** and **AH2/118-INQ000493710** (this followed some debate with the Star Chamber as to the administration of the scheme, as recorded in the notes and advice which I exhibit for completeness as **AH2/119-INQ000338511, AH2/120-INQ000337108**, and **AH2/121-INQ000337201**). On 21 October 2020, in light of the delayed launch of the Carers Support Grant, Ministers agreed to allocate an additional £50,000 to support Carers Trust Wales to swiftly disseminate the fund (MA/JM/3563/20, exhibited at **AH2/122-INQ000145070**).

265. On 30 December 2020, given the high demand for grants, Ministers agreed to the allocation of additional funding of £250,000 to the Carers Support Grant, plus £27,500 for administration costs. I exhibit the Ministerial Advice at **AH2/123-INQ000493728.** For completeness, I add that the Carers Support Grant remains in place, Ministers having agreed funding of £4.5m over three years, from 2022-23 to 2025-26 (MA/JMSS/1738/22, exhibited at **AH2/124-INQ000493737**).

266. Separately, and in recognition of the impact of Covid-19 on unpaid carers who struggled to cope without access to face-to-face support, or a break from their caring role, the Minister for Health and Social Services and the Deputy Minister for Health and Social Services agreed (in response to advice submitted on 16 March 2021 (MA/JM/0035/21), exhibited at **AH2/125-INQ000144988**), to commit £3m to extend and improve respite services for carers, in two tranches: £1.75m to local authorities to fund emergency respite services, to be allocated in April 2021, and a further £1.25m to manage a short breaks fund, to be allocated in September 2021. The Welsh Government issued updated guidance to those providing unpaid care, which I exhibit at **AH2/126-INQ000081803** and published its Strategy for Unpaid Carers in March 2021, for which an Equality Impact Assessment was prepared, and which I exhibit at **AH2/127-INQ000514869**.

267. A short breaks scheme for unpaid carers remains in place, Ministers having agreed funding of £9m over three years, from 2022-2023 to 2025-26 (MA/JMSS/0586/22, exhibited at **AH2/128-INQ000493736**.

268. On 9 March 2022, the Minister for Health and Social Services and the Deputy Minister for Social Services agreed to allocate £29.75 million to cover the cost of a £500 one-off payment to unpaid carers in Wales. Ministers had received advice (MA/JMSS/0894/22, exhibited at **AH2/129-INQ000499750)**, which recommended this allocation of funding as a response to the financial pressures unpaid carers were facing, and recognised that social care workers had received recognition payments from the Welsh Government during the pandemic, but unpaid carers had not. The advice confirmed that an Equality Impact Assessment had been carried out to ensure that the proposal was compliant with the Welsh Minister's Public Sector Equality Duty. I exhibit the Equality Impact Assessment at **AH2/130-INQ000514871**.

269. Given that welfare benefits were (and remain) a reserved matter in Wales, the Welsh Government could not follow the Scottish Government's model of awarding bi-annual uplifts to the Carers Allowance. Nor could it access the contact details of people resident in Wales and in receipt of the Carers Allowance because no agreement was in place with the UK Government to allow that information to be shared. However, the UK Government had agreed to an approach whereby local authorities administered the payments using receipt of Carers Allowance as an eligibility criterion. Only carers in receipt of Carers Allowance on 31 March 2022 were eligible. The scheme was announced by the Deputy Minister in a Written Statement on 23 March 2022, which I exhibit at **AH2/131-INQ000496061**.

Hospital discharge decisions during the pandemic

270. The hospital discharge process implemented during and since the pandemic has understandably elicited significant concern and reflection among various stakeholders, including health and care professionals, policy makers, patients, and their families. The unprecedented nature of the pandemic necessitated rapid decision-making in extraordinarily challenging circumstances, where the primary focus was to protect patient safety by preventing hospital overcrowding. Decisions were often made under immense pressure, with incomplete information and evolving understanding of

the virus. Consequently, while the guidance around hospital discharge aimed to streamline the discharge process and ensure continuity of care, it also highlighted the complexities and ethical dilemmas inherent in managing healthcare during a global health emergency. This period, undoubtedly, highlighted the need for continual evaluation and adaptation of discharge protocols to better prepare for future public health challenges and crises.

"Discharge to recover then assess" policy

271. I am asked to provide a summary of the process by which patients were discharged prior to the pandemic, including a summary of the "discharge to recover then assess" policy. As with admission, the decision to discharge a person from hospital has always been a clinical decision. While national or local guidance on discharge was in place prior to (and during) the pandemic period, clinical teams are always advised to ensure that patients are fully suitable for discharge following a clinically led review.

272. In the period leading up to the pandemic there had been work undertaken to assess the discharge process in line with commitments made in 'A Healthier Wales'. In 2018 the NHS Wales Delivery Unit undertook a review of complex discharge across Wales based on the National Programme for Unscheduled Care[12] 'Every Day Counts' programme. This included implementation of the 'home first' ethos and Discharge to Recover then Assess ("D2RA") pathways. The NHS Delivery Unit had been working to support health boards and local authorities with local implementation of the Discharge to Recover then Assess pathway.

273. The Discharge to Recover then Assess was predicated on the evidence that hospitals were not always the best place for frail people to receive services. Evidence suggested that hospital stays for frail people, particularly frail older people, could reduce mobility, physical and cognitive ability, bring about loss of independence and greater reliance on long-term care. This pre-pandemic work on discharge arrangements underpinned the Covid-19 hospital discharge guidelines (which I outline in more detail below). The Discharge to Recover then Assess model formed the basis

[12] The NHS Wales Programme for Unscheduled Care is a long running programme established to facilitate and enable change and improvement for unscheduled health and care services in Wales. This Programme is overseen by the Emergency Ambulance Services Committee which is a Joint Committee of all local health boards.

of the Covid-19 guidelines to help protect people from exposure to the virus in institutions and maximise capacity in service provision. A report outlining the work on right sizing community services to facilitate discharge (using the Discharge to Recover then Assess model) was published in May 2020. A copy of a joint letter to health boards, local authorities and Regional Partnership Boards from myself and Andrew Goodall to note the publication of the report is exhibited in **AH2/132-INQ000227162** and the report itself exhibited in **AH2/133-INQ000227163.**

Expedited discharge of vulnerable patients

274. On 13 March 2020, the Minister for Health and Social Services made a statement exhibited at **AH2/134-INQ000198262** explaining that he had agreed a framework of recommended national actions within which local health and social care providers could make decisions in order to provide care and support to the most vulnerable people in our communities, whilst also making sure organisations and professionals were supported to make timely preparations for the expected increase in the number of confirmed cases of Covid-19. The framework included, amongst many other actions, the expedited discharge of vulnerable patients from acute and community hospitals, and the suspension of the then current 'choice guidance' which gave the right to a choice of care home in cases where a hospital patient was being discharged into a social care setting.

275. I am asked whether I or the Social Services and Integration Directorate were consulted regarding the framework that was announced on 13 March 2020. I do not recall this occurring prior to 13 March 2020, including in relation to the decision to include in the framework actions to expedite the discharge of vulnerable patients from acute and community hospitals into care settings, and the suspension of the then current 'choice guidance'.

276. The framework was circulated to me at midday on 13 March 2020 **AH2/135-INQ000252511** in advance of a briefing meeting later that day with Andrew Goodall and the First Minister, ahead of the statement being published that evening.

277. I note that in developing the framework, engagement was undertaken with stakeholders including NHS Wales Chief Executives and the Royal Colleges. I am not aware of social care stakeholders being consulted as part of this engagement. As

such, I am unable to comment as to the extent to which PPE levels and testing capacity were considered as part of the development of the framework, though I know they were important issues at this time. Further, the workstreams and groups that I have referred to in this statement were established to ensure the practicalities around issues such as provision of testing and PPE to the social care sector were taken forward, with the aim of supporting anticipated requirements emerging from the framework.

278. I appreciated that this was not a usual set of circumstances and that decisions had to be taken quickly, and that while in the course of routine business I would have been consulted beforehand, these were exceptional circumstances, and we had to move incredibly quickly to try to match the pace of the pandemic and information flow.

279. The purpose of the framework of 13 March 2020 was to help ensure timely hospital discharges during the pandemic and to eliminate any delays related to care home choice, thereby ensuring hospital beds would be available to support a surge in hospital demand as well as avoiding inappropriate and risky extensions to a patient's stay in hospital where there might have been a higher risk of infection. These measures were formalised on 20 March 2020, through MA/VG/1004/20 (**AH2/136-INQ000366593**), which set out the growing consensus amongst the clinical community that acute hospital capacity should be released in a phased way, ensuring that preparations could be put in place for admitting vulnerable non-Covid-19 patients, anticipating a large surge in demand, and ensuring that patients were placed in safer environments. The advice was approved by Dr Andrew Goodall. At this time, Reasonable Worst Case Scenario modelling indicated a 30-fold increase requirement in the availability of critical care beds and that immediate action was necessary to create significantly increased levels of hospital beds, equipment and staff. I exhibit the modelling at **AH2/137-INQ000252031**.

280. I am asked to provide an overview of Wales's testing regime as it existed at the time of this decision on 13 March 2020. I have been provided with this information from the relevant part of the Health and Social Services Group. I understand that the UK Government made the decision to end community testing on the same day as the framework was announced, on 13 March 2020. As confirmed in the fifteenth SAGE meeting that day, it was thought that this would increase the pace of testing (and delivery of results) for intensive care units, hospital admissions, targeted contact tracing for suspected clusters of cases, and healthcare workers. This includes faster

confirmation of negative results. A copy of the minutes of this meeting are exhibited in **AH2/138-INQ000509415.**

281. At the same time, Public Health Wales provided advice on testing which in summary recommended the testing of both patients and health care workers, and others, if recommended by health board Medical Directors. This advice was communicated to the NHS in Wales via the Chief Medical Officer (Wales) on 13 March 2020: **AH2/139-INQ000048570**. The Chief Medical Officer (Wales) noted that keeping health care workers off work for seven days following the onset of symptoms pending a negative result would be detrimental to the safe running of the service compared to providing negative results at day two or three to allow them to return to work. The Minister for Health and Social Services issued a statement confirming this on 18 March 2020, a copy of which is exhibited in **AH2/140-INQ000198641**.

282. On 18 March 2020, I attended a Covid Core Group meeting with the First Minister, exhibit **AH2/141-INQ000336350** refers. The Chief Medical Officer (Wales) informed us that the virus was probably circulating in the community — there were 136 cases in Wales and two fatalities. The Chief Scientific Adviser for Health advised that it appeared that the UK was four weeks into the curve, and it was expected to be another eleven weeks before the spread of the virus peaked, whereas the NHS was four to five weeks away from maximum capacity. This was an alarming picture and the threat of the NHS reaching maximum capacity so quicky re-enforced that urgent preventative action was necessary.

283. On 19 March 2020, NHS England published its guidance on hospital discharge arrangements ("UK Government Hospital Discharge Guidance"), exhibited at **AH2/142-INQ000049701**. No-one within the Health and Social Services Group, nor within the rest of the Welsh Government as far as I am aware, was involved in any discussions with the UK Government or NHS England before that guidance was published. It first came to the Group's attention via officials in the NHS in Wales on 20 March 2020, and was circulated more widely within the Group on 23 March 2020.

284. This prompted discussions within the Welsh Government about whether we needed to develop guidance for Wales, which was quickly decided necessary. On 23 March 2020, Lynda Chandler was re-deployed from the NHS Wales to the Health and Social Services Group, specifically to review the NHS England guidance and to develop guidance for Wales. A first draft was circulated the same day: see the email chain at exhibit **AH2/143-INQ000499591**. I will refer to this guidance as the "Welsh

Government Hospital Discharge Guidance". This guidance was not specific to the care sector and was intended to reflect the broad framework announced on 13 March 2020 and applied to the whole health and social care sector.

285. Around this time, concerns were raised with the Welsh Government about the effect of the expedited discharge of vulnerable patients into social care settings. On 20 March 2020 I chaired a meeting of the Social Care Planning and Response Sub-Group. This meeting noted that there was limited testing capability, which would increase from 800 to 5000 per day as of 1 April 2020. It was noted that healthcare and social care workers were to be prioritised: **AH2/144-INQ000338491**. On 22 March 2020, Lee Waters (a Member of the Senedd), raised a query on behalf of Ty Mair care home in Llanelli which had been asked to take patients from what they termed a "Covid-19 positive hospital": **AH2/145-INQ000336323**. The care home stated that the patients were not showing symptoms but felt that these individuals should be either isolated or tested, to protect other residents. I responded to this correspondence detailing that PPE should be used when patients who were positive for Covid-19 were discharged from hospital to a care home and that testing was not available due to limited capacity at this stage, and indicated that further guidance on this would be issued. I noted that testing capacity would increase at the beginning of April. I followed up this email on the next day, 23 March 2020, advising that residents would need to self-isolate, and that PPE should be worn when dealing with confirmed or suspected cases of Covid-19, exhibit **AH2/146-INQ000336324** refers.

286. It is also important to note that PPE supplies were not yet at the level whereby PPE could be advised for use for those that were potentially asymptomatic. On 19 March 2020 there had been a statement by the Minister for Health and Social Services indicating that work was being done to ensure that PPE was available for the social care sector, as referred to later in this statement at paragraph 454. Arrangements were put in place whereby care providers could obtain PPE from local health boards.

287. Care providers and commissioners also required clarity and guidance regarding testing prior to discharge from hospital to enable safe and appropriate care once in a care setting and I asked that we sought further advice from Public Health Wales, which in turn would be shared with providers and commissioners by way of correspondence.

288. On 22 March 2020, a ministerial briefing was drafted by the Health and Social Services Planning and Response Group and is exhibited at **AH2/147-INQ000300089**.

It set out the structure of the group and its sub-groups and identified 24 temporary actions taken by the group, including ensuring clarity on testing of health and social care workers and ensuring supply of PPE to care home staff, which was to be done by 23 March 2020 — in the meantime there were mutual aid agreements in place between local authorities.

289. On the morning of 24 March 2020 there was discussion amongst Social Services and Integration Directorate officials regarding the need to obtain advice from Public Health Wales, to inform the letter that was to be sent out to the sector giving further guidance on hospital discharge, **AH2/148-INQ000499595**. Later that day, Social Services and Integration Directorate's head of care home inspection and regulation policy spoke to Public Health Wales, and this was followed up with an email, **AH2/149-INQ000499596**), stressing that it was important that any advice provided by the Welsh Government to care home providers and commissioners was consistent with and informed by up-to-date Public Health Wales advice. This was followed up again the next day on 25 March 2020 by email, **AH2/150-INQ000499597**.

290. Also on 24 March 2020, Public Health England produced version 7 of the paper '*Are asymptomatic people with Covid-19 infectious?*'. It described cases of asymptomatic infection but said that these: *"do not provide evidence for asymptomatic transmission of SARS-CoV-2. The currently available data remains inadequate to provide evidence for major pre-symptomatic/asymptomatic transmission of (Covid). Major uncertainties remain in assessing the influence of pre symptomatic transmission on the overall transmission dynamics of the pandemic... Detailed epidemiological information from more cases and contacts is needed to determine whether transmission can occur from asymptomatic individuals or during the incubation period on a significant scale."* As previously stated, had testing capacity allowed, I would have advocated a precautionary approach even in the absence of evidence regarding asymptomatic transmission. Even so, I was acutely aware that advice was needed by the sector and in the early stages and beyond during the pandemic, it was made available to care settings, such as Public Health Wales guidance on resident isolation, the use of PPE, Infection, Prevention and Control measures and other guidance, based on SAGE advice published 16 March 2020 which included advice to over 70s to follow social distance guidance rigorously. That guidance stated that vulnerable individuals (such as the elderly and those with underlying medical conditions) should be kept as separate as possible for the duration of the stay at home policy.

291. Also on 24 March 2020, I was notified that my team were still working with Public Health Wales on a letter to send out to care home providers regarding hospital discharge, **AH2/151-INQ000336335**. I was keen that this was progressed as quickly as possible.

292. On 26 March 2020 Public Health Wales confirmed with policy colleagues that a team comprising infectious disease consultants and micro-biologists were still considering the evidence and research to formulate Public Health Wales advice and help inform my correspondence to the sector, **AH2/152-INQ000499598**.

293. On 26 March 2020, Mary Wimbury, the Chief Executive of Care Forum Wales, sent an email to the Health and Social Services Group raising concerns that a Covid-19-positive patient had been discharged to a care home, and that the care home had been given no advice or support. I exhibit this email as **AH2/153-INQ000499600**. On 28 March 2020, Darren Millar MS sent an email to Tracey Cooper, Chief Executive of Public Health Wales, on behalf of several care home providers who had contacted him, raising concerns that new residents were not being tested for Covid-19 prior to admission, and asking why this was: **AH2/154-INQ000336344**. Tracey Cooper in her reply stated that new residents should be assessed for signs or symptoms of the virus and isolated as appropriate, and that if new or existing residents did not have any symptoms prior to admission, there was no value in testing. Early in the pandemic, Public Health Wales observed in meetings with Welsh Government policy officials that test results were most reliable at the time when they were taken. They expressed concern that testing might create a false sense of security, potentially leading to a relaxation of infection prevention and control measures where results were negative. Public Health Wales felt that maintaining infection prevention and control measures was a more effective strategy to prevent the spread of Covid-19.

294. On 27 March 2020, Ministerial Advice (MA/VG/1136/20), exhibited at **AH2/155-INQ000136770**, was submitted to the Minister for Health and Social Services attaching the Welsh National Covid-19 Test Plan, exhibited at **AH2/156-INQ000349273**. The Test Plan confirmed that one of the six workstreams was scaling testing for patients, vulnerable groups and front-line staff. The lead for that work-stream was Public Health Wales. The fourth work-stream was point of care testing to control future outbreaks in, amongst others, care homes.

295. Policy officials continued to work on the Welsh Government Hospital Discharge Guidance, and the NHS Delivery Unit's Performance Improvement Manager circulated the draft on 30 March 2020, exhibit as **AH2/157-INQ000336353**. In that email chain, officials discussed the need for Ministerial Advice to be prepared regarding the funding of care and support packages for people discharged from hospital during the pandemic. Within the same email chain, on 31 March 2020, the NHS Delivery Unit's officer stated that she had been advised that the issue of testing upon hospital discharge needed to be addressed and included in the guidance. The Deputy Chief Medical Officer for Wales Chris Jones stated in reply that *"I would think no place for testing prior to discharge as negative one day can be positive the next."* Social Services and Integration Directorate's head of care home inspection and regulation policy replied on 31 March 2020 saying that she had been trying make progress with Public Health Wales to seek up to date advice and expressed some frustration with this. I had also spoken with Public Health Wales on 30 March, and was told the urgency was understood. I was concerned by this point that we did not yet have advice from Public Health Wales and that in some instances, care homes and domiciliary care providers were refusing to accept people without prior testing at the point of hospital discharge. I was equally concerned that the testing capacity was not yet at such as level as to allow testing of potentially asymptomatic patients in any event.

296. It was clear that there was a need for guidance specifically directed to the care sector, but as illustrated above, advice from Public Health Wales was still in development. Discussions between the Welsh Government and Public Health Wales officials continued, with different Public Health Wales personnel taking the lead and becoming the main points of contact for the guidance, in particular Andrew Jones, Deputy Director of Public Health Services and Director of Integrated Health Protection, as well as Jyoti Atri, Director of Health and Wellbeing, and Julie Bishop, Director of Health Improvement and Consultant in Public Health.

297. On 2 April 2020, Social Services and Integration Division's head of care home inspection and regulation policy emailed officials thanking them for everything that they were doing to get the care homes guidance ready for issue the following day: **AH2/158- INQ000512940**. That email set out a list of the type of queries that the Welsh Government was receiving from Care Inspectorate Wales and others, which included: re-admission of existing residents after a hospital stay; new admissions with or without Covid-19; how best to protect other residents in a setting if the provider

accepts an individual who has had Covid-19 and may still pose a risk of infecting others; advice on self-isolation for new admissions or re-admissions; practical guidance on how to manage a number of people with symptoms; and advice on the position on testing and what was deemed necessary.

298. On 2 April 2020, guidance on the admission and care of residents in care homes was published for England by the UK Government Department for Health and Social Care, Public Health England, the Care Quality Commission, and NHS England ("UK Government Guidance on the Admission and Care of Residents in Care Homes", which I exhibit as **AH2/159-INQ000325255**). Again, no-one within the Health and Social Services Group, nor within the rest of the Welsh Government as far as I am aware, was involved in any discussions with the UK Government or NHS England before that guidance was published. In relation to hospital discharge, the guidance expressly stated that *"negative tests are not required prior to transfers / admissions into the care home".*

299. On 3 April 2020 I received written advice from the Deputy Chief Medical Officer (Wales), exhibit **AH2/160-INQ000336377**, in response to a request for advice made by the Minister for Health and Social Services following a meeting with local government, during which concern was expressed that there was community transmission and that care workers were not being prioritised compared to those in the NHS – although this was not specific to hospital discharge. The advice was that the risk to care home workers was likely to be less than in hospital because residents were self-isolating, and visitors were prohibited and that steps had been taken to ensure that all care homes had access to PPE if they had a resident who had tested positive for Covid-19. Inappropriate and/or unnecessary use of PPE would mean less for other purposes. I am not aware of any instances of care homes running out of PPE during the pandemic.

300. Public Health Wales circulated a draft proposed letter on 3 April 2020, which Welsh Government officials and Care Inspectorate Wales reviewed. Margaret Rooney, Deputy Chief Inspector at Care Inspectorate Wales replied stating that she thought that care home providers would be expecting and needing more, and that she considered a Welsh equivalent of the UK Government Guidance on the Admission and Care of Residents in Care Homes was required. Also on 3 April 2020, in a separate email thread, Public Health Wales circulated a draft of their proposed guidance, **AH2/161-INQ000514733**. On reviewing this, Social Services and Improvement Division's head of care homes inspection and regulation policy informed

Public Health Wales that the Welsh Government's preference was for more comprehensive guidance to be provided to the sector, covering the relevant issues in one place as far as possible. It was also noted that timing was key for the care homes guidance, because the queries from the sector were increasing.

301. Another example of the continuing queries from the care sector was an email received from Community Housing Cymru sent to the Welsh Government and Care Inspectorate Wales on 4 April 2020, which raised several concerns including that those being discharged from hospital into care settings included individuals with Covid-19 and who were still displaying symptoms: **AH2/162-INQ000499614**. In the same email thread, Social Services and Integration Division's head of care homes inspection and regulation policy highlighted key outstanding considerations such as the question of care homes accepting people who remained "Covid-19 infectious". She noted that Public Health England guidance indicated that this could be done safely with the right procedures but anticipated concern from providers in Wales.

302. Meanwhile, Welsh Government officials continued to engage proactively with Public Health Wales officials about the need for sector guidance. Public Health Wales developed a more substantial guidance document for care homes, based on the UK Government Guidance on the Admission and Care of Residents in Care Homes, and draft guidance documents were circulated to Welsh Government officials on 6 April 2020 **AH2/163-INQ000336379** and 7 April 2020 **AH2/164-INQ000227015**, the latter including a draft cover letter to be shared with providers. On 7 April 2020, Margaret Rooney raised concerns regarding the content of the guidance, particularly regarding care homes being required to accept Covid-19 positive patients. She emphasised that if providers approached Care Inspectorate Wales for advice, they would advise them of their on-going *"responsibility (and legal duty) to make the decision whether they can care for and meet a person's needs taking into account the resources and facilities they have and the needs of the existing residents living at the home, before they agree to provide care."* **AH2/165-INQ000396527**.

303. On 8 April 2020, Gillian Baranski (Chief Inspector, Care Inspectorate Wales) stated in an email to Welsh Government officials that having read the guidance, she was *"very concerned at the implication that providers must now accept new residents with Covid 19, irrespective of whether there are currently confirmed cases in their home or not."* She felt unable to support the guidance as it was presented. **AH2/166-INQ000198281**

304. Later in the morning on 8 April 2020, Margaret Rooney confirmed that Care Inspectorate Wales was not content for the guidance to branded with its logo and that she had taken part in a conference call with a range of international regulators, many of whom had reported that they believed that they had focused on care homes too late, which had ultimately contributed to a rising curve of transmission. **AH2/167-INQ000396510**.

305. Public Health Wales replied to Care Inspectorate Wales's concern within the same thread, stating *"we have stuck to the PHE technical content and believe this is the right thing to do. This content has been well thought through. If we do not get these people back out into the community our hospitals will not be able to cope with the demands being placed upon them. The guidance covers the requirements on the home to minimise the risk of spread."* The email is exhibited at **AH2/168-INQ000198569**.

306. Later in the evening on 8 April 2020, in an email to the Welsh Government and Public Health Wales officials, Margaret Rooney re-iterated the same concerns further, while acknowledging that testing capacity remained a challenge, **AH2/169-INQ000198288**.

307. During this time, on 7 April 2020, the final version of the Welsh Government Hospital Discharge Guidance was published and circulated on 8 April 2020 under a cover letter sent to local health boards and Regional Partnership Boards from myself and Andrew Goodall: **AH2/170-INQ000227334** and **AH2/171-INQ000236770**[13]. As noted above, this guidance was not specific to the care sector, and did not set out any conditions (such as testing) for the discharge of hospital patients to social care settings.

308. It was clear by this point that Public Health Wales was taking the same position as Public Health England with the technical content of the care homes guidance, and that it was certain that returning people into the community was of paramount importance to support the NHS to cope with the additional demand on services. I, along with policy colleagues in my directorate, was concerned at the conflict between expediting hospital discharge to create capacity, and potential risks arising by

[13] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227022]*

returning or placing people vulnerable to the effects of Covid-19 back into care homes. This was a very difficult situation where decisions could only be taken by considering what was known at that time. It was clear that if discharges were not 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, the Deputy Chief Medical Officer (Wales), Public Health Wales, and evidence regarding the possibility of asymptomatic transmission; while testing of all patients upon discharge would have been preferred, without sufficient testing capacity it was not possible. However, I wished to make it clear to care homes and providers that they needed to be satisfied that they could safely care for any individual before accepting responsibility for their care.

309. On the evening of 8 April 2020, I approved the final version of the Public Health Wales Guidance on Admission and Care of Residents during the Covid-19 Incident in a Residential Care Setting in Wales and the cover letter under which the guidance would be circulated to the sector, subject to the Deputy Chief Medical Officer (Wales) confirmation that he was also content for both of these to be issued: **AH2/172-INQ000396514**. The Deputy Chief Medical Officer (Wales) gave his confirmation later that evening: **AH2/173-INQ000336397**. I exhibit a copy of the guidance as **AH2/174-INQ000283271**[14] and a copy of the letter, which was signed by me and the Deputy Chief Medical Officer (Wales) on 9 April 2020, as **AH2/175-INQ000338279**.

310. As with the UK Government guidance, the Public Health Wales guidance stated that *"Negative tests are not required prior to transfers / admissions into the residential setting"*. It also stated: "*some of these patients may have Covid 19, whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed.*" The Public Health Wales guidance advised a risk assessed approach, stating: "*The discharging hospital will clarify with care homes the COVID-19 status of an individual and any COVID-19 symptoms, during the process of transfer from a hospital to the care home. Public Health Wales will assist residential settings and hospital discharge teams in risk assessing whether it is safe and appropriate for an individual to return to a care setting*". The covering letter from me and the CMO(W) stated: "*Care home services have an essential role to play in helping to manage this emergency by ensuring that people can be discharged safely from*

[14] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000336402]*

hospital when they no longer need to be there. We recognise that there will be a number of considerations to take into account and that you will need to be satisfied that you can provide safe care for that individual".

311. Throughout this period, Social Services and Integration Directorate policy officials engaged proactively with Public Health Wales officials to ensure that timely, bespoke technical guidance was produced for, and issued to, the social care sector. My team within the Social Services and Integration Directorate continued to be involved in discussions with the Deputy Chief Medical Officer (Wales) in relation to the discharge of patients from hospital into care settings. It remained the case, as at the date of the publication of the Public Health Wales guidance on 9 April 2020, that testing capacity was not yet at the level that would have been required to test all patients upon discharge from hospital into a care home.

312. I am asked to comment on several aspects of the discharge decision of 13 March 2020 which I will now address.

Assessment of number of patients to be discharged

313. I am asked whether the Health and Social Services Group carried out an assessment of the numbers of patients that would be discharged in March and April 2020 as a result of the decision, and the number of care home beds that would be needed to accommodate those discharged patients.

314. An assessment of Covid-19 related hospital discharge numbers during the pandemic was completed and circulated to local authority Directors of Social Services on 27 April 2020. I exhibit the letter at **AH2/176-INQ000499637** and an example of the provided data for the Aneurin Bevan University Health Board area at **AH2/177-INQ000501503**. This data was shared to allow local authorities to ensure there were sufficient beds to accommodate hospital discharges, especially in the context of the decision to expedite discharges to create more hospital capacity for Covid-19 patients from 13 March 2020 and beyond.

315. The aim of the modeling exercise was to ensure that care homes could accommodate these discharges without being overwhelmed, while still providing adequate care for both existing residents and new admissions.

316. The data provided a breakdown by health board / Regional Partnership Board area based on each of the NHS step-down pathways, showing likely demand for residential and care at home services against each pathway, using the hospital discharge model developed by Professor John Bolton (discussed elsewhere in this statement).

Suspension of the right to a choice of care home

317. I am asked to explain the rationale that led to the suspension of a patients' right to a choice of care home as part of the framework that was announced on 13 March 2020.

318. By way of background, under Part 4 of the Social Services and Well-being (Wales) Act 2014, a local authority may meet a person's care and support needs by providing accommodation. Regulations were made under section 57 of the 2014 Act (*The Care and Support (Choice of Accommodation) (Wales) Regulations 2015* (as amended)) which provide that where the person concerned has expressed a preference for particular accommodation of that type, the local authority must provide or arrange for the provision of the preferred accommodation, if the conditions specified in those Regulations are met. These provisions are supported by the Welsh Government-issued Code of Practice on Charging for Social Care Services. A copy of the Code can be provided to the Inquiry on request, if required.

319. Section 15 and Part 2 of Schedule 12 of the Coronavirus Act 2020 was commenced in relation to Wales 1 April 2020. The effect of these provisions was that local authorities in Wales did not have to comply with certain duties in relation to meeting needs, and carrying out assessments under the 2014 Act, and certain specified duties to meet needs under the 2014 Act were modified. The Coronavirus Act 2020 allowed easements to the requirements in the Choice of Accommodation Regulations in specified circumstances. These easements were to give local authorities discretion to respond to extreme pressures on services or workforce shortages. We understand that in practice local authorities continued to comply with the choice of care home obligations as they existed before the pandemic.

320. These provisions remained in operation until 23 March 2021, when the ability of local authorities to operate these easements was suspended. The provisions were repealed in relation to Wales on 30 July 2021.

321. Separately, local health boards are subject to duties to offer choice of care homes at the point of discharge from hospital under the National Assistance Act. These duties are accompanied by guidance (often referred to as the "Choice Policy"), which sets out requirements intended to ensure effective management of the choice process when discharging patients from hospitals to a care home. The choice process is operated by local health boards in the form of individual choice protocols. During the pandemic, the Choice Policy was suspended.

322. The purpose of suspending these provisions and processes was to make sure that no-one remained in hospital awaiting discharge to their choice of care home, if that care home did not have immediate capacity to receive the person. It is important to note that the suspension of the choice guidance did not permit indiscriminate discharge into care home settings. The setting discharged to (an interim placement until the individual's care home of choice became available) would still be suitable to the needs of the person being discharged. Instead, the effect of the suspension was that the person would no longer be able to wait in an acute or community care setting until their preferred suitable setting became available.

323. The emphasis was on moving patients out of hospital to somewhere safer and more suitable for recovery, whilst still meeting their needs, as soon as they no longer needed hospital care. I exhibit a letter sent to Directors of Social Services and local health board Chief Executives on 17 December 2021, reminding them of these principles: **AH2/178-INQ000499746**.

Consideration of care home capacity to manage risk of Covid-19

324. I am asked to outline the consideration given to the capacity and ability of care homes to adequately manage the risk of Covid-19 infection of people living in care homes and staff, in relation to the framework of actions announced on 13 March 2020.

325. These were important factors to consider. The swift implementation of the framework prompted questions about the preparedness of some care homes to accommodate a sudden increase in patients, especially those with complex health

needs. Early experiences of PPE, testing, and other resources also presented increased challenges in managing the risk of infection.

326. Ongoing assessment and support mechanisms were put in place to monitor the evolving situation in care homes, address emerging issues, and provide additional resources as needed. This took the form of the aforementioned Health and Social Services Planning and Response Group, and its Social Care sub-group, and the Social Care Coordination Hub within the Social Services and Integration Directorate also acted as a central point of contact with sector leaders and with the Welsh Government's Emergency Co-ordination Centre (Wales).

327. Establishing feedback mechanisms to gather input from care homes regarding the challenges faced and the effectiveness of the support provided was essential. Assessments were made regarding the availability of beds and facilities in care homes to accommodate an increased number of residents and continuous engagement was maintained with partners such as Care Inspectorate Wales, and Directors of Social Services, which helped to facilitate such evaluations and feedback.

328. Consideration was also given to the existing staffing levels in care homes and across the care sector and their ability to manage an influx of patients with potentially higher care needs. An assessment of the availability of PPE, and other resources required to manage Covid-19 infections was also conducted on a continuous basis through routine meetings established from the onset of the pandemic. Social Services and Integration Directorate policy colleagues also liaised extensively with internal and external health colleagues to ensure sufficient supplies, suitable guidance and practical assistance was made available throughout the pandemic, aligned with the evidence for best practice in care homes as advised by health experts such as Public Health Wales.

329. Ensuring that care homes had robust infection control measures in place, including isolation protocols for new admissions, routine testing of residents and staff, and hygiene practices, was also considered essential and guidance and practical assistance was made available throughout the pandemic.

330. It became clear early on that updated guidelines for care home staff on managing Covid-19 risks, including the use of PPE, symptom monitoring and infection prevention strategies would be necessary. The importance of establishing clear communication channels between hospitals, care homes and health boards to

facilitate the safe transfer of patients and sharing of patient and treatment information was also recognised and developed throughout the pandemic. Implementing support systems, such as access to public health advice, emergency response teams and mental health support for staff, was also given early consideration.

Decisions made in relation to discharging patients to care homes that were rated as 'poor'

331. I am asked to set out any decisions made in relation to discharging patients to care homes rated as 'poor', as part of the framework of actions announced on 13 March 2020.

332. There was no rating system in operation in social care in Wales in the period leading up to, or during, the pandemic. Further, the Welsh Government has never been involved with individual hospital discharge decisions (including the care home into which a patient is to be discharged) or the exercise of clinical or social worker expertise. Patients should only be discharged to a care home that can meet their needs and this position did not change during the pandemic.

Care and Support Capacity Tool

333. I am asked to explain the Health and Social Services Group's involvement in and use of the Care and Support Capacity Tool. To clarify, the Care and Support Capacity Tool was often referred to within the Welsh Government as the Care Home Capacity Tracker and these two names were used interchangeably.

334. The purpose of the Care and Support Capacity Tool was to provide an online facility containing up-to-date data relating to the capacity of all care homes across Wales, including bed occupancy and vacancies. The initiative was developed independently of the pandemic. However, in response to Covid-19, the plans for the development of the Tool changed and a modified version of it was implemented for all care home providers to use, in order to better understand care home capacity during the pandemic. This modified version of the Tool, which was formulated in conjunction with Data Cymru and Care Inspectorate Wales, went live on 26 March 2020. I wrote to care home providers on 26 March 2020 alerting them to the availability of the Tool and encouraging them to use it: **AH2/179-INQ000500149**. In early April 2020, the

Minister for Health and Social Services agreed to continue funding for a further year to manage, maintain and embed the Tool which I exhibit at **AH2/180-INQ000500164**.

335. Once the Tool was introduced, it was intended that the vacancy information submitted by providers would be used to inform planning, based on an enhanced understanding of fluctuations in care home capacity across the sector. However, initially the information provided via the Tool was of limited value, as many providers either did not use it consistently or update it whenever vacancy information in the home changed.

Health and Social Services Group's understanding of the impact of the March discharge policy

336. I am asked to comment on the Health and Social Services Group's understanding of the impact of the March discharge policy on the following:

a. Covid-19 infection rates in residential and nursing homes and mortality rates;
b. Recipients of care;
c. Staff in those care homes;
d. Those discharged to their own home.

337. During the pandemic, the Health and Social Care Capacity Monitoring and Modelling Group met monthly, from mid-2020. The Group produced a report each month which brought together a range of data on the impact of Covid-19 on the health and care sector – including, for example, increased demand on services. These reports were not specific to the impact of the March discharge policy and were not specific to the care sector, but I refer to this initiative here because it demonstrates the steps taken within the Welsh Government to monitor the impact of the pandemic on health and social care as those impacts were being experienced at the time. I exhibit by way of example the report from January 2021 **AH2/181-INQ000499706** and from November 2021 **AH2/182-INQ000499744**.

338. In November 2020, a report was published by Swansea University Medical School which had been commissioned by Public Health Wales, regarding the effect

of hospital discharge on Covid-19 rates in care homes: **AH2/183-INQ000213185**[15]. The report concluded, based on data analysis on care home updates and discharge rates, that hospital discharges were not a significant factor in the spread of Covid-19 to resident care in Wales.

339. More generally, the impact of the March discharge policy was felt across service providers, which had been experiencing staff shortages since before the pandemic, as the Welsh Government was aware. During the pandemic, staff numbers were affected further due to sickness and isolation requirements, and as a result the discharge policy put additional strain on an already stretched workforce. The driving factor, as I have said, was the need to get people out of hospitals for their safety and to free up capacity in response to the expected surge in Covid-19 patient admissions into Welsh hospitals. This made it more challenging for care homes to maintain their usual standards of care, and as a result, many residents experienced disruptions in their care and well-being during this period.

Further developments in relation to hospital discharge decisions and testing in April 2020

340. Following the publication of the Welsh Government Hospital Discharge Guidance on 7 April 2020 and the Public Health Wales Guidance on Admission and Care of Residents during the Covid-19 Incident on 8 April 2020, the Welsh Government continued to receive reports of concerns from the adult social care sector regarding the impact of the discharge of patients from hospitals into care homes. On 8 April 2020, Mary Wimbury, Chief Executive, Care Forum Wales, wrote a letter to the First Minister asking for urgent disclosure of the Welsh Government's risk assessment underpinning current safe discharges from hospitals to care homes: **AH2/184-INQ000499629**. The letter stated providers had reported being pressured into admitting patients from hospitals and felt they could only safely do so with adequate PPE and appropriate testing. The Deputy Minister for Health and Social Services replied to this letter on 1 May 2020 (by which time testing arrangements for discharged patients had changed, as I outline below): **AH2/185-INQ000501332**.

[15] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000224074]*

341. On 10 April 2020, Ministers requested that a note be issued by the Chief Medical Officer (Wales) to Care Forum Wales to provide clarity and reassurance around the testing of patients being discharged from hospitals into care homes, reiterating that testing was available for social care staff: **AH2/186-INQ000497036**. This prompted the letter that was then sent out in my and the Chief Medical Officer's name, also on 10 April 2020, which emphasised that the Welsh Government was working to rapidly increase testing: **AH2/187-INQ000336404**.

342. On 10 April 2020 the Technical Advisory Cell met, **AH2/188-INQ000313229**, and considered the Chief Medical Officer (Wales)s discussion paper for the Recovery Plan in Wales v.0a. Paragraph 8 of the Recovery Plan stated: *"It should be noted that any lifting of interventions put in place to increase social distancing in the UK are based on multiple assumptions. These include... transmission is possible from mild and even asymptomatic cases".* The point was repeated at paragraph 11a. I exhibit the paper at **AH2/189-INQ000215241**. At this stage the possibility of transmission from mild and asymptomatic cases was considered an 'assumption'.

343. However, on 14 April 2020, the Technical Advisory Cell briefing for the Chief Medical Officer (Wales), exhibited at **AH2/190-INQ000220420**, referred on page 4 to the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) paper `Duration of infectiousness following symptom onset in COVID', which recommended: "Particular caution should be exercised in Covid-19 patients discharged from hospital to nursing homes, homeless shelters, or other institutions where there are vulnerable individuals." At page 5 it noted the SAGE advice that there were three distinct parts to the epidemic: community, hospitals and social care, with a different pattern of transmission in each. It stated that there was insufficient data around cause of death in care homes to estimate R in that setting although the number of outbreaks in care homes was almost certain to be increasing. The table at page 8 identified an excess death category as being related to additional pressures on the health and social care system but the mitigation identified related to health only — it said nothing about the social care system. On page 13 it noted that 87% of Covid-19 related deaths took place in hospital, 6% in care homes and 6% took place in private homes.

344. This latest Technical Advisory Cell briefing and SAGE advice made clear to me that a new approach to hospital discharge guidance was needed in relation to testing as the number of outbreaks in care homes was *"almost certain to be increasing".*

345. The following day on 15 April 2020, the UK Government's Department for Health and Social Care published its Action Plan for Adult Social Care, **AH2/191-INQ000233794**[16]. This contained the new requirement in England to test all patients before discharging them from a hospital into a care home. Again, I do not recall any advance notice given by the UK Government Department for Health and Social Care in relation to this.

346. Also on 15 April 2020, I attended the Covid-19 Core Group meeting, exhibit **AH2/192-INQ000336472** refers. We were told that 81 care homes had reported Covid-19 infections. This further compounded my intention to seek additional advice from Public Health Wales and a revised approach to testing upon discharge from hospital.

347. On the afternoon of the same day, 15 April 2020, there was a Ministerial meeting to discuss social care, at which the Deputy Minister for Health and Social Services stated that feedback from Care Forum Wales and Care Inspectorate Wales indicated that there was great concern about hospital discharge into care homes and testing of patients on discharge, and that this needed to be addressed. **AH2/193-INQ000336415**. The minutes of this meeting noted testing as an area which required more work, and that the Chief Medical Officer (Wales) was to consider the policy around testing of patients when leaving hospital to go into a care home.

348. Later, on 15 April 2020, Social Services and Integration Directorate's head of inspection and regulation policy sent an email to Public Health Wales stating that I and the Chief Medical Officer (Wales) wanted a revised approach to testing in place as soon as possible, to include testing on hospital discharge and more general testing for care home residents and staff: **AH2/194-INQ000336416.** Dr Marion Lyons (senior medical officer in Health and Social Services Group Public Health Division) emailed a more detailed request to Public Health Wales on 16 April 2020, which I exhibit at **AH2/195-INQ000500170**.

349. On 17 April 2020, a meeting took place between Welsh Government officials and Public Health Wales: **AH2/196-INQ000336421**. In relation to hospital discharge, the note of the meeting records that Welsh Government officials verbally outlined a policy instruction from me and the Chief Medical Officer (Wales) for the testing of non-

[16] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000325315]*

Covid-19 patients prior to discharge from hospital to care home settings. Social Services and Integration Directorate's head of care home inspection and regulation policy emailed me shortly after the meeting with an update: **AH2/197-INQ000499632** and advised that she and Margaret Rooney had explained the concerns of care home providers in relation to the issue of testing before hospital discharge. The update also recorded that Public Health Wales officials felt that there had not been a clear steer or instruction from the Welsh Government, and Andrew Jones (from Public Health Wales) who chaired the meeting had indicated that the Minister for Health and Social Services had taken a different position on testing the previous day.

350. There was also a Ministerial update issued to the Minister for Health and Social Services and the Deputy Minister for Health and Social Services on 17 April 2020, which confirmed the change in policy and stated that officials were working with Public Health Wales to produce a testing delivery model for care home residents and staff, which would be completed over that weekend and available by 20 April: **AH2/198-INQ000336423**.

351. Later on 17 April 2020, Dr Marion Lyons sent an email to Public Health Wales confirming that it would provide the necessary testing in support of the new policy, and that the Welsh Government had requested that Public Health Wales should provide a brief paper on the mechanisms by which both staff and care homes would have access to prompt testing and support: **AH2/199-INQ000499635**. Public Health Wales complied with this request on 20 April 2020, when a draft was sent to Dr Lyons: **AH2/200-INQ000501496**. The draft was shared with Care Inspectorate Wales the following day, and Margaret Rooney replied with her comments on 21 April 2020, saying that she was disappointed that the draft still stated that people could be admitted to a care home with a positive Covid-19 test or active symptoms. Social Services and Integration Directorate's head of care home inspection and regulation policy replied confirming that she had spoken to Public Health Wales and asked it to amend the note to reflect that patients would not be discharged until the test result was known. I exhibit a copy of the updated guidance in respect of Step-up & Step-down Care Arrangements during the COVID-19 period, issued on 29 April 2020 at **AH2/201-INQ000081080.**

352. On 22 April 2020, I sent a joint letter with the Chief Medical Officer (Wales) to all care home providers and local authorities confirming that testing would be undertaken before hospital discharge and that both the Welsh Government Hospital

Discharge Guidance and the Public Health Wales Guidance on Admission and Care of Residents during the Covid-19 Incident would be updated: **AH2/202-INQ000336444**.

353. Following this, on 24 April 2020, the Chief Medical Officer (Wales) and I sent a further letter to local health boards which confirmed the change in policy and that updated guidance was to be published, and which also stated that health boards and trusts needed to ensure that there were systems in place both to test individuals 48 hours before their planned discharge from hospital, and to test care home residents and those in the community prior to a planned transfer or admission to a new care home: **AH2/203-INQ000227087**.

354. On 24 April 2020, an email was shared summarising a meeting I had attended with Directors of Social Services, in which queries had been raised by the local authorities regarding, among other things, when there would be testing before discharge for all patients returning to the community who received domiciliary care: **AH2/204-INQ000198308**. Care Inspectorate Wales also indicated it would like that to be in place as soon as possible and also referred to discussions that it had held with Care Inspectorate Scotland in relation to testing of care workers there, a number of whom had been Covid-19 positive without displaying symptoms.

355. Also on 24 April 2020, Social Services and Integration Directorate's head of care home inspection and regulation policy asked Public Health Wales for an update as to when their revised Guidance on Admission and Care of Residents during the Covid-19 Incident would be completed: **AH2/205-INQ000198311**. Margaret Rooney repeated her concerns about asymptomatic care home staff testing positive and stated that her view was that all staff and residents in care homes should be tested whether or not they were symptomatic, and that such testing should be repeated at regular intervals.

356. Public Health Wales sent an initial draft of the revised guidance to Welsh Government officials on 27 April 2020, but it was considered that this draft was not consistent with the letter that I and the Chief Medical Officer (Wales) had sent out to the sector. I exhibit an exchange of emails between the Social Services and Integration Directorate and Public Health Wales as **AH2/206-INQ000499639**. I also exhibit an update which policy officials sent to me on 28 April 2020 which outlined the significant difficulties that they were experiencing with Public Health Wales in trying to make headway with the revised guidance: **AH2/207-INQ000499643**.

357. During this time, Welsh Government officials had been working on an updated version of the Welsh Government Hospital Discharge Guidance, which was published on 29 April 2020: **AH2/201-INQ000081080**. This made clear that a negative test was required before any individual was discharged from hospital to an existing placement or care package and included those receiving support in their own home or supported living facilities.

358. The updated version of the Public Health Wales guidance was published under its new title "Guidance to Prevent COVID-19 Among Care Home Residents and Manage Cases & Outbreaks in Residential Care Settings in Wales" on 7 May 2020, as Version 3: **AH2/208-INQ000198367**. The updated guidance referred to the letters of 22 and 24 April 2020 and confirmed that the Welsh Government's policy required health boards to test all individuals being discharged from hospital to a step down or care home setting regardless of whether they were admitted to hospital with Covid-19, and that people would not be admitted to a care home without a negative test.

359. Throughout this period, Welsh Government officials worked proactively with Public Health Wales officials to ensure the publication of updated Public Health Wales guidance which was consistent with the Welsh Government's stated approach to testing and published guidance on hospital discharge.

Reflections on decisions regarding hospital discharge decisions during the pandemic

360. During the Covid-19 pandemic, producing the best advice and guidance for the care sector was an extraordinarily challenging task, largely due to the fast-paced and rapidly evolving nature of the crisis. The pandemic presented an unprecedented public health emergency, more often requiring swift action based on incomplete and constantly changing information.

361. The scientific understanding of the virus, its transmission, and effective control measures developed rapidly. Early in the pandemic, there was limited knowledge about how the virus spread, the effectiveness of different types of PPE, and the best strategies for testing and isolation. Guidance had to be updated frequently as new information emerged, making it extremely difficult to establish stable protocols for care homes for example.

362. The urgency to protect the most vulnerable people added immense pressure to provide clear and effective guidance. This urgency sometimes led to decisions being made with the best available information at that time, which later had to be revised as new data became known.

363. Policy makers had to balance various conflicting priorities, such as preventing the spread of the virus, maintaining the mental and emotional well-being of care home residents, and ensuring that care homes had adequate resources and staffing. For example, strict isolation measures could protect residents from infection but also lead to significant social isolation and mental health concerns. Achieving the right balance was an ongoing challenge and incredibly difficult to do.

364. Limited resources, including shortages of PPE, testing kits, and staffing, further complicated the response. Ensuring that care homes were adequately equipped while managing supply chain disruptions and high demand across the healthcare system required difficult prioritisation.

365. Clear and consistent communication was essential but difficult to maintain. Guidance had to be disseminated quickly and comprehensively to a wide range of stakeholders, including care home providers, managers, staff, residents, and families. Ensuring that everyone understood and adhered to rapidly changing protocols was a significant challenge, exacerbated by varying levels of resources and capabilities among different care homes. The fragmented nature of social care provision with many different providers equally posed logical challenges.

366. In retrospect, the experience highlighted the need for more robust emergency preparedness plans tailored specifically for care settings, developed at all levels of the system (i.e. government, local authority, and provider level). It highlighted the importance of rapid research, data collection, transparent communication, and flexible yet consistent guidance. Going forward, these lessons are informing our work on pandemic preparedness and will lead to a more resilient systems capable of responding more effectively to future public health crises.

367. In the event of a future pandemic, the Health and Social Services Group would make several key changes to the process of discharging patients from hospitals to care homes. The pandemic highlighted significant challenges and areas for improvement in this process. With hindsight now available to us, a range of practices that we would implement in the event of a future pandemic are as follows:

Enhanced Infection Control Measures

i. **Mandatory Testing**: Implementing mandatory testing for all patients before discharge as soon as capacity allows. This would help to protect vulnerable care home residents and staff.

ii. **Isolation Protocols**: Establishing isolation protocols for new admissions to care homes, where patients are isolated for a period before joining the general population of the care home, where capacity in a care home or step-down facility allows. Availability of single room occupancy in care homes is important for maintaining both an individual's dignity and effective infection control, especially before routine testing becomes available.

Improved Communication and Coordination

iii. **Better Coordination**: Strengthening coordination between Public Health Wales, hospitals, care homes, and local health boards to ensure seamless transition and clear communication of any potential risks.

iv. **Data Sharing**: data sharing regarding patient testing results, and care requirements to ensure continuity of care.

Resource Allocation

v. **Adequate Staffing**: Ensuring that the care sector is adequately staffed. This might include deploying additional temporary staff to care homes.

vi. **Resource Provision**: Ensuring the care sector can access sufficient personal protective equipment (PPE) and other necessary resources as well as ensuring early access to appropriate infection prevention and control guidance, to manage potential outbreaks effectively. A pandemic preparedness stockpile continues to be maintained by the NHS Wales Shared Service Partnership.

Policy and Guidelines

vii. **Clear Guidelines**: Developing clear guidelines and protocols for discharge processes, ensuring that all health and care providers understand and follow these protocols.

viii. **Emergency Preparedness Plans**: Implementing robust emergency preparedness plans, to include the consideration of the needs of the care sector, including contingency plans for outbreaks and surge capacity.

Monitoring and Evaluation

ix. Regular Audits: Conducting regular audits and evaluations of discharge processes to identify and address any issues promptly.

x. Feedback Mechanisms: Establishing mechanisms for feedback from care homes, residents, and families to continuously improve discharge practices.

Restrictions on visits to care settings

368. I have been asked to set out in chronological order the Health and Social Services Group's involvement in the key visiting guidance to nursing and residential homes during the relevant period. Again, the Welsh Government's involvement in visiting guidance during the pandemic was carried out by my directorate.

369. Before I turn to the detail of my directorate's involvement in the production of visiting guidance to the adult social care sector, it is important for me to make the point that care home providers were required to comply with the general Covid-19 related legislative restrictions in the same way that other businesses and members of the public were. The guidance that the Welsh Government provided in relation to visits to care homes was non-statutory guidance and was intended to support providers to make decisions about visits within this regulatory framework. I also wish to emphasise that my team and I were very conscious of the serious distress experienced by many people and their families, as well as the challenges that providers and their staff were facing throughout this period. We recognised and acknowledged this throughout the pandemic, and our aim with visiting guidance was to provide practical, proportionate and rights-based guidance to facilitate visits within the context of wider legislative restrictions.

Guidance on visits to care homes, March to June 2020

370. The first piece of guidance that was communicated by the Welsh Government to the sector in relation to visits was on 23 March 2020, when I sent a letter to all registered providers and responsible individuals of care home services in Wales, Directors of Social Services, and Chief Executives of health boards. In this letter I stated that visits to care homes should now only take place when essential and not as part of routine visiting, and that non-essential providers such as hairdressers and entertainers should no longer enter care homes, along with any non-essential contractors or service providers: **AH2/209-INQ000336332**. I stated that any request for a visit for a specific purpose felt to be absolutely essential should be made to the care home manager for a decision; I also recognised that sensitive discussion would need to take place around residents receiving end of life care; and I emphasised the need for regular phone calls with family and friends to maintain social contact.

371. This letter followed a meeting that took place between the First Minister and the Minister for Health and Social Services, which I also attended, on 22 March 2020, at which it was agreed that the advice on visits to care homes needed to be clarified, in light of the emerging SAGE advice on the rate of transmission at that time: **AH2/210-INQ000336319**.

372. The letter also followed the publication of Public Health England's guidance on residential care provision on 13 March 2020, which advised care homes to suspend visits where a person was suspected to have Covid-19 or was generally unwell.

373. After my letter of 23 March 2020, I sent another letter, co-signed by the Chief Medical Officer (Wales), to registered providers, responsible individuals, Directors of Social Services, and Chief Executives of health boards, on 9 April 2020: **AH2/211-INQ000336279**. The main purpose of this letter was to alert the recipients to the Public Health Wales Guidance on Admission and Care of Residents during Covid-19, which I address in more detail in the section of this statement that deals with hospital discharge decisions. The letter also included a reminder that non-essential visitors to the home should be restricted.

374. On 27 May 2020, I met with the Older People's Commissioner to discuss visits to care homes. At this meeting, the Older People's Commissioner and I agreed that guidance for the sector on visits should be co-produced (meaning produced in conjunction with the sector), even though this would be a more time-consuming

approach. The Older People's Commissioner also stated that it was important that people understood that there was light at the end of the tunnel, with plans being formed to reinstate visits to care homes in a safe way: **AH2/212-INQ000502004**.

375. On 1 June 2020, following the 21-day review of the Coronavirus Regulations, the "stay at home" message was changed to "stay local", and two households were permitted to meet outdoors provided social distancing and good hygiene practices were observed. Following this change, both the Welsh Government and Care Inspectorate Wales received a lot of queries regarding the position on care home visits, from the Older Person's Commissioner, organisations, and family members, as I recorded in an informal briefing that I provided to the Deputy Minister for Health and Social Services: **AH2/213-INQ000499647.** On 5 June 2020, I wrote to care home providers offering assistance with planning outdoor visits based on advice from Public Health Wales: **AH2/214-INQ000198403**. That advice included, for example, that providers should ensure that visits only took place if the home was Covid-19-free, that a risk assessment should be carried out for all types of visits, that visits should be limited to two people from the same household and that social distancing should be observed at all times. The letter also indicated that the Welsh Goverment was working with Public Health Wales and Care Inspectorate Wales to produce more detailed guidance to support providers with making decisions on enabling visits to take place and inviting any thoughts and ideas to be submitted via an online form, which was managed by Care Inspectorate Wales.

376. In the period between 23 March 2020 and 23 June 2020, the Welsh Government received a number of letters from members of the public, Members of the Senedd and Members of Parliament raising concerns regarding the detrimental impact of visiting restrictions on care homes residents, particularly those with dementia and I exhibit two examples of such letters at **AH2/215-INQ000501979** and **AH2/216-INQ000501982**. I also continued to engage with the Older People's Commissioner during this period, who reported to me the concerns that were raised with her by friends, family, and staff at care homes: see for example the note of my meeting with the Older People's Commissioner on 3 June 2020, **AH2/217-INQ000498679**. Separately, the Deputy Minister for Health and Social Services also continued to meet with the Older People's Commissioner: see for example the note of the meeting on 17 June 2020 **AH2/218-INQ000498699**.

377. On 25 June 2020, version 1 of the Welsh Government's Visits to care homes: Guidance for providers was published, **AH2/219-INQ000081250**. As indicated in my

letter of 5 June 2020, this guidance was informed by advice received from Public Health Wales and feedback collated by Care Inspectorate Wales, who convened a stakeholder group which met on 1 June, 2 June and 11 June 2020 and which reviewed drafts of the guidance before it was published. Version 1 reflected both the changes in national restrictions that came into force on 1 June 2020 (outdoor visits), and also the changes that came into force on 22 June 2020, from which date travel out of the local area was permitted on compassionate grounds. The First Minister in his statement announcing the change stated that compassionate grounds may include visiting a loved one who needed help or visiting someone outdoors in a care home, **AH2/220-INQ000023247**. The guidance continued to recognise that there would be exceptional cases, including individuals receiving end of life care, where indoor visits would be permitted, and provided advice to care home providers in making such decisions. I exhibit the underlying Ministerial Advice as **AH2/221-INQ000144921**.

378. Version 2 of the guidance was then published on 7 July 2020, updated to reflect the removal of the "stay local" message (meaning that people were free to travel within and into Wales) from 6 July 2020. This was the only amendment made in version 2 of the guidance.

Version 3 of the guidance on visits to care homes, 28 August 2020: indoor visits

379. Version 3 of the guidance was published on 28 August 2020: **AH2/222-INQ000337012.** This was a significant update because it supported the reintroduction of routine indoor visits. This change reflected the relaxation in the national restrictions from 22 August 2020, when up to four households could form an extended household, enabling those individuals to meet indoors. Under version 3 of the guidance, care home residents could nominate one designated visitor for indoor visits along with a nominated deputy if for any reason the designated visitor could not attend, provided certain criteria were met (including that there was no outbreak of Covid-19 in the home and that the visitor adhered to infection prevention and control measures during the visit).

380. Version 3 of the guidance was informed by advice from Public Health Wales and, as with the previous version, produced with the stakeholder group, which met on 11 August 2020. As is reflected in the advice to Ministers that recommended the change, **AH2/223-INQ000136803**, version 3 was produced in response to concerns that had been raised by the Older People's Commissioner, and others, regarding the

negative impact that the restrictions on visits and physical separation from loved ones were continuing to have on people's emotional, mental and even physical health. The advice noted increasing correspondence from and on behalf of families who were beginning to despair; it acknowledged that outdoor visits were not always the solution, being weather-dependent, staff-intensive and simply not always suitable or possible. The advice noted that there was clear appetite and calls for indoor visits to resume but also genuine concern from providers about the risk of re-introducing infection and the risk to other residents. It acknowledged that the possibility of a second wave of Covid-19 infection would mean that the opportunity for visits, including outdoor visits, would diminish, meaning that there was a limited window in which to enable indoor visits while community transmission levels were low. Advice had been obtained from the Welsh Government's Health Protection teams and the Technical Advisory Cell as to the conditions that should be in place before routine indoor visits to care homes could take place (including, as was reflected in version 3 of the guidance, that there should be no Covid-19 outbreak in the home and that the visitor should comply with infection prevention and control measures during the visit). I exhibit a letter that I sent to the sector on 21 August 2020 announcing the guidance: **AH2/224-INQ000116019**[17]. Further Ministerial Advice was provided once the guidance had been produced, seeking approval of the draft before publication on 28 August 2020: **AH2/225-INQ000116706.** The advice was cleared by the Chief Medical Officer (Wales), and shortly after publication an integrated impact assessment was carried out which considered the equality impact of the reintroduction of indoor visits: **AH2/226-INQ000136989**[18].

Visits to care homes during local restrictions, September 2020

381. From early September 2020 onwards, local restrictions were in place in certain areas that were experiencing particularly high rates of Covid-19. This began with the imposition of local restrictions covering Caerphilly County Borough Council, which were in place from 8 September 2020. Under these restrictions, which were implemented as updates to the Coronavirus Regulations, residents were not able to

[17] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000500353]*

[18] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000337419]*

enter or leave the area without reasonable excuse, and there was a prohibition on indoor meetings, though people were allowed to meet outdoors. Caerphilly County Borough Council announced that, as part of those local restrictions, all visits to care homes would cease with immediate effect (including outdoor visits). The same decision to cease all visits to care homes was also made in many of the other local areas where local restrictions were subsequently imposed, following Caerphilly; again, these were local decisions taken by the local authority acting in collaboration with the Incident Management Team. For clarity, under the Coronavirus Regulations at that time, visiting care home residents could be considered an exceptional reason to travel, especially under compassionate grounds. This included visiting residents who were nearing the end of life, or where the absence of visitors could severely impact the mental health and well-being of the resident.

382. On 10 September 2020, the Deputy Minister for Health and Social Services met with the Older People's Commissioner. A number of matters were discussed at that meeting, including how the new local restrictions would affect care home visiting restrictions in those local areas, as reflected in the email that the Older People's Commissioner sent the day after the meeting, on 11 September 2020: **AH2/227-INQ000349852**. In that email, the Older People's Commissioner stated that it was unclear to her why outdoor visits to care homes had been suspended, when outdoor contact was still permitted in Wales under the Regulations.

383. At another meeting between the Deputy Minister and the Older People's Commissioner on 16 September 2020, the Commissioner again expressed concern about the imposition of restrictions on outdoor visits in certain local areas, as recorded in an email that a member of my directorate sent to other Welsh Government officials as well as Public Health Wales and Care Inspectorate Wales later that day: **AH2/228-INQ000498682**. The email recorded that discussions with Dr Marion Lyons (who chaired the Outbreaks and Incidents sub-group of the Welsh Government's Health Protection Advisory Group, which was involved in monitoring transmission rates and localised outbreaks of the virus) had indicated that no Incident Management Team meetings had taken place in two of the areas where restrictions on outdoor visits to care homes had been implemented (Carmarthenshire and Ceredigion), though Public Health Wales did subsequently confirm that the Incident Management Teams for other areas in respect of which the same issue had been raised (Newport/ Caerphilly/Rhondda Cynon Taf/ Merthyr) had reconsidered the restrictions on outdoor

visits and concluded that these should remain suspended due to the risks to residents: **AH2/229-INQ000498683, AH2/230-INQ000499666, AH2/231-INQ000499668.**

384. The Older People's Commissioner sent a further letter to Public Health Wales on 21 September 2020, regarding her concerns about the suspension of outdoor visits in care homes in areas where local lockdowns were in place: **AH2/232-INQ000184951**. Although this letter was not copied to the Welsh Government, it was provided to policy officials by Public Health Wales, and Andrea Street attended a further meeting that then took place between Public Health Wales and the Older Person's Commissioner to discuss the concerns.

385. On 23 September 2020, the Deputy Minister for Health and Social Services issued a statement which confirmed that local authorities in "hotspot areas" subject to local restrictions, working in collaboration with public health experts, had made the difficult decision to temporarily suspend visiting to care homes in all but the most compassionate of cases to protect residents from the risk of infection and illness: **AH2/233-INQ000498717**. The Deputy Minister confirmed her full support of these decisions being made locally and in collaboration with Public Health Wales through Incident Management Teams to ensure that a balance could be maintained between protecting people's public health from the risks posed by the virus and their continued wellbeing. The Deputy Minister also stated that it was important that opportunities for visiting continue to be sustained in areas where it remained safe to do so.

386. Also on 23 September 2020, I sent a letter, in conjunction with Care Inspectorate Wales, to local authority Directors of Social Services: **AH2/234-INQ000198486**. The letter emphasised the importance of local authorities continuing to work with Public Health Wales when considering whether to impose local restrictions on visits to care homes, and stated that the local Incident Management Teams would consider the available information to make recommendations in relation to visits and that, by following this process, we could collectively reassure people that restrictions were being imposed only when absolutely necessary and to the extent absolutely necessary on the basis of sound advice. The letter emphasised that visits to people in care homes in exceptional circumstances, such as those receiving end of life care, would continue to be permitted even if local restrictions were imposed. The letter also directed the Directors of Social Services to notify Care Inspectorate Wales if restrictions on care home visitors were imposed or lifted within the local authority.

387. On 28 September 2020, the Older People's Commissioner issued a statement entitled Care Home Visiting in Wales, in which she set out her concerns about the impact of suspending care home visits on older people's health, wellbeing and quality of life, and called for renewed action to enable visits to continue with appropriate measures to ensure the safety of residents and staff: **AH2/235-INQ000181756**. The statement underlined the importance of face-to-face contact between older people living in care and their loved ones, and the position that decisions around visiting should be taken on a case-by-case basis rather than applying blanket decisions.

388. On 2 October 2020, I sent a follow-up letter to my letter of 23 September 2020 to local authority Directors of Social Services, providing further clarity on the position relating to visits, having received a number of queries: **AH2/236-INQ000337149**. I exhibit an example of such a query as **AH2/237-INQ000499670** and a query raised within the Welsh Government by the Social Services and Integration Directorate as **AH2/238-INQ000499672**. In the letter, I confirmed that decisions about restricting visits to care homes – either routine indoor visits, outdoor visits, or both – in a local authority area subject to local lockdown restrictions, were made by the individual local authorities. I stated that local authorities were encouraged to make such decisions collaboratively using the local Incident Management Teams process with input from Public Health Wales, and that social services should be represented in discussions relating to any decisions made about care homes. The letter repeated that even where restrictions on routine indoor visits were in place, both local authorities and care home providers were asked to ensure that appropriate and sensitive arrangements were made to support indoor visits in compassionate and exceptional circumstances such as end of life. The letter also stated that outdoor visits should be supported to continue wherever possible, and that it was important to avoid an unnecessarily restrictive blanket approach and that visits were supported where safe and possible.

389. On 7 October 2020, the Deputy Minister for Health and Social Services met with the Older People's Commissioner: **AH2/239-INQ000350558**. At this meeting, there was a discussion about visits to care homes, and the Older People's Commissioner confirmed that she was content with the guidance that I had provided in my letter of 23 September 2020. The Older People's Commissioner also stated that she was pleased that a number of care homes in areas subject to local lockdowns were continuing to facilitate outdoor visits.

390. From 23 October 2020 until 9 November 2020, the firebreak lockdown was in place in Wales, during which time there was a general prohibition on people meeting with anyone outside their own household either indoors or outdoors. This applied equally to care homes, subject to the same provision for visits to take place in exceptional circumstances, including end of life care. I remained strongly in support of retaining the ability to visit vulnerable people in care homes, wherever possible and with local risk assessment, as I set out in an email on 14 October 2020 discussing the proposed firebreak restrictions: **AH2/240-INQ000499678**.

Visits to care homes after the firebreak, from 9 November 2020

391. On 6 November 2020, I sent a letter to providers confirming that the new post-firebreak Regulations permitted care home visits, and that local authorities should advise care home providers on the approach to care home visits in the local authority area **AH2/241-INQ000116172**[19]. Local authorities were again encouraged to make these decisions collaboratively using the local Incident Management Team process with input from Public Health Wales, with social services represented in any discussions that concerned care homes. I repeated that, as before, it was important to avoid an unnecessarily restrictive blanket approach and that visits to care homes were supported where safe and possible; and again, as before, I asked that even when restrictions were placed on routine indoor visits, local authorities and care home providers should ensure that appropriate and sensitive arrangements were made to support indoor visits in exceptional circumstances including, but not restricted to, end of life visits.

392. On 9 November 2020, I am aware that the then First Minister, Mark Drakeford, attended a 'CDL' call (between the Chancellor of the Duchy of Lancaster, and the First Ministers of Scotland, Wales and Northern Ireland), at which the First Minister raised the question of whether lateral flow tests could be relied on in order to open up visiting in care homes: **AH2/242-INQ000198980**. The First Minister acknowledged the "really heartbreaking" set of restrictions that had been in place in care homes.

393. On 23 November 2020, Ministers announced the launch of a pilot scheme to support care home providers in accommodating socially distanced visits by providing

[19] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000498685]*

a limited number of visiting pods (which would enable visits to take place in an outdoor space during the winter months), for a trial period of twenty-six weeks. The intention was for the trial period to help understand whether visiting pods were an effective and practical way to support meaningful visits. I exhibit the Ministerial Advice underlying the decision to fund the pilot scheme as **AH2/243-INQ000337440** and the written statement as **AH2/244-INQ000498718**.

394. On 25 November 2020, the Deputy Minister met with the Older People's Commissioner: **AH2/245-INQ000221103**. Care home visits were discussed at this meeting and the Deputy Minister emphasised that policy officials were exploring other ways of supporting providers to facilitate visits.

Visits to care homes over the Christmas period, December 2020

395. The Welsh Government published a Frequently Asked Questions (FAQ) guide for outward visits from care homes over the Christmas period on 18 December 2020 (before the decision to move Wales into Alert Level 4, as announced on 19 December 2020): **AH2/246-INQ000081680**. The guide referred to the general rule on household mixing which was in place at that time (i.e. that two households were able to come together to form a bubble for a five-day period over Christmas) and confirmed that this applied to residents of care homes, who should be supported by the care home provider and by their family or friends to ensure a safe Christmas visit or a meal, should they want to do this. An Integrated Impact Assessment was undertaken in relation to the advice for care homes on going out at Christmas, which I exhibit at **AH2/247-INQ000137002**.

396. An updated Frequently Asked Questions guide was published on 22 December 2020 following the move to Alert Level 4 in Wales from midnight on 19 December 2020: **AH2/248-INQ000498689**. This reflected the change in rule such that two households were only able to mix for one day, on Christmas Day, which applied to care home residents.

397. On 23 December 2020, the Coronavirus Control Plan: Alert Levels in Wales for Social Care Services was published, **AH2/249-INQ000081729**. The Control Plan provided guidance on visits to care homes (among other matters) according to which Alert Level applied. It stressed that the general approach should be one of local and

individual risk assessment, with blanket approaches to be avoided and that providers were encouraged to facilitate visits wherever possible; but that general indoor visiting was not advised during an incident, other than in exceptional circumstances including, but not restricted to, end of life visits. In Alert Level 4 specifically, general indoor visiting was not advised save for in exceptional circumstances, though risk assessed outdoor visits could take place with one designated outdoor visitor.

398. While it remained the case throughout this period that visits to care homes were allowed in exceptional circumstances, which included and were not limited to end of life care, I am aware that there was some confusion in the way that this was interpreted. In addition, there continued to be reluctance from some care homes to facilitate visits at all. Welsh Government officials continued to meet regularly with local authorities and Public Health Wales during this period, as well as with organisations representing care home providers, such as Care Forum Wales, and those advocating for residents, such as the Older People's Commissioner, to discuss these concerns and to continue to encourage visits to take place where possible and within the scope of the rules. Care Inspectorate Wales also continued to engage with the stakeholder group on the same basis.

399. In the period between 1 November and 31 December 2020, the Welsh Government received letters from, or on behalf of, family members of individuals living in care homes, care home managers, and local authorities. The letters from the public emphasised the distress and heartbreak people felt at being unable to see their loved ones in care homes in a meaningful way. The letters spoke of the mental, emotional, and physical toll the Covid-19 restrictions had taken on their loved ones living in care homes, particularly those with dementia or learning disabilities who may not have understood the reasons for their families' absence. Many people requested clarification on the visiting rules for care homes and reported a lack of contact that was inconsistent with the Welsh Government's guidance at the time, indicating an overly cautious approach from some care home providers. There was a spike in the number of letters leading up to the Christmas period as people sought clarification on the visiting rules, particularly regarding whether residents would be required to isolate following a visit out of the care home and whether window visits were permitted. The letters from care home managers similarly sought clarification on the visiting rules. The Welsh Government considered all letters individually and responded sensitively and in a timely way, providing links to the latest guidance and other relevant information.

Version 4 of the guidance on visits to care homes, 1 February 2021: Alert Levels

400. The next iteration of the guidance was published on 1 February 2021, as version 4: **AH2/250-INQ000081815**. This reflected the guidance that had already been provided in the Coronavirus Control Plan: Alert Levels in Wales for Social Care Services referred to above, which had been published on 23 December 2020 and which, as noted above, set out the guidance on what visits were possible within each Alert Level. Wales remained in Alert Level 4 at this time, in which one designated visitor was permitted for outdoor visits or visits in a pod provided there was no outbreak at the home, and with indoor visits permitted in exceptional circumstances. The Chief Medical Officer (Wales) and I sent a letter out to providers alerting them to the updated guidance, and reminding them of the Control Plan, on 1 February 2021: **AH2/251-INQ000498694**. I also exhibit the Ministerial Advice underlying the updated guidance as **AH2/252-INQ000136841**.

Version 5 of the guidance on visits to care homes, 12 March 2021: indoor visits resumed

401. On 22 February 2021, the UK Government announced that care home residents in England would be permitted one designated visitor from 8 March 2021. On 25 February 2021, Public Health Wales provided advice to Welsh Government officials (which was passed on to me) supporting a careful, managed relaxation of the restrictions then in place to enable indoor visits to take place in Alert Level 4, subject to various control measures, including the nomination of a single designated visitor/ deputy, use of PPE, social distancing, and lateral flow testing of the visitor: **AH2/253-INQ000337529**. This fed into Ministerial Advice recommending that this change be implemented from 12 March 2021: **AH2/254-INQ000198557**.

402. The change was publicly announced by the Deputy Minister for Health and Social Services on 4 March 2021, **AH2/255-INQ000498698**, and there was discussion with the sector about the practicalities of resuming indoor visits at a meeting between the Deputy Minister for Health and Social Services, and representatives of Care Forum Wales, the Older People's Commissioner, local Incident Management Teams, and Directors of Social Services, on 10 March 2021. I also discussed the change at my regular meeting with Directors of Social Services on 11 March 2021: **AH2/256-INQ000499729**.

403. The updated guidance was published as version 5 on 12 March 2021: **AH2/257-INQ000081899**. The guidance included reference to the importance of taking decisions while also considering general legal obligations, such as those under the Equality Act 2010 and Human Rights Act 1998, as applicable. It also stated that providers should facilitate visits wherever it was possible to do so, in a risk managed way. I also exhibit the Ministerial Advice underlying version 5 of the guidance: **AH2/258-INQ000116680**.

Version 6 of the guidance on visits on care homes, 26 April 2021: indoor visits with two designated visitors

404. The UK Government announced that care home residents in England would be permitted two designated visitors each who could participate in routine indoor visits (though not at the same time) from 12 April 2021. On 15 April 2021, the stakeholder group convened by Care Inspectorate Wales met to consider the proposal that the same change should be made in Wales and was broadly supportive of this.

405. The updated guidance was published as version 6 on 23 April 2021, with the change effective from 26 April 2021: **AH2/259-INQ000498703**. I also exhibit the Ministerial Advice underlying version 6 of the guidance: **AH2/260-INQ000116701.** Public Health Wales also published a Frequently Asked Questions (FAQ) document to support its own guidance on risk assessments for visits into or out of care homes on 21 April 2021. I exhibit the guide to risk assessment at **AH2/261-INQ000501661** and the Frequently Asked Questions document at **AH2/262-INQ000501662**.

Version 7 of the guidance on visits to care homes, 14 May 2021: indoor visits

406. A further update to the guidance was published on 14 May 2021 as version 7, under which two designated visitors were permitted for routine indoor visits, and those visitors were able to attend at the same time (socially distancing, if they were not members of the same household) as well as separately: **AH2/263-INQ0000338239**. The Chief Medical Officer (Wales) and I sent a covering letter out to providers announcing the new guidance and indicating the intention to lift restrictions on the overall number of indoor visitors from 24 May 2021: **AH2/264-INQ000337677**. Our letter also highlighted the importance of residents being supported to leave the care home for visits out if they wanted to do so.

Further updates to the guidance after 14 May 2021

407. There were further updates to the guidance after version 7 was published on 14 May 2021:

a. Version 8 was published on 24 May 2021 and removed the requirement for a designated visitor and deputy designated visitor, though retained the limitation on the number of visitors at any one time to two per resident: **AH2/265-INQ000082053**.

b. Version 9 was published on 16 July 2021 and reflected the national move into Alert Level 1 from 17 July 2021, removing the requirement for residents to self-isolate following an overnight stay away from the care home, and allowing indoor visits from entertainers: **AH2/266-INQ000498705**.

c. Version 10 was published on 6 August 2021, removing the limit of two visitors at a time, with this now being determined by the individual provider subject to a risk assessment: **AH2/267-INQ000275822**.

d. Version 11 was published on 8 October 2021, removing the need for social distancing and easing the restrictions around bringing gifts into the home: **AH2/268-INQ000498709**.

e. Version 12 was published on 22 November 2021, enabling more routine visiting into and out of care homes to take place during some outbreaks, and to enable residents who were self-isolating after discharge from hospital to receive visitors in the care home: **AH2/269-INQ000082428**.

f. Version 13 was published on 15 December 2021, and introduced changes because of the Omicron variant, including that visits out of the home should cease during an outbreak, and that visitors into the home should be restricted to essential visits only during an outbreak in the home: **AH2/270-INQ000082181**. A Frequently Asked Questions document was also published to address common questions about the festive period: **AH2/271-INQ000082472**.

g. Version 14 was published on 28 January 2022 and reflected to move to Alert Level 0 in Wales. It enabled more routine visiting into and out of care homes to take place during some outbreaks and re-emphasised the importance of supporting residents to go out of the home if they wanted to do so: **AH2/272-INQ000082608**.

Reliance on 'blanket' guidance

408. I am asked to comment on the extent to which blanket guidance was given in relation to visits to adult social care settings in Wales, irrespective of the particular needs of people living in care homes. It was not the case that there was ever 'blanket' guidance in place in Wales. From the very first iteration of the guidance that I have outlined above – version 1, published 25 June 2020 – providers were given a list of questions and points to consider when determining whether a request for a visit should be facilitated on the basis of exceptional circumstances, including end of life care or compassionate reasons. This was also made clear in the letter that I sent out to providers on 23 March 2020, before any guidance had been published: as I set out earlier in this statement, that letter stated that visits to care homes should only take place when absolutely essential, and that any request for a visit for a specific purpose should be made to the care home manager for a decision. The letter expressly recognised that sensitive discussions would need to take place around end-of-life care.

409. The guidance also recommended an ethical framework be relied on by providers when making decisions regarding the provision of adult social care during the pandemic, taking into account a non-exhaustive list of principles that included the need for flexibility and proportionality, which were listed in the guidance. The guidance explicitly recognised that one size did not fit all, and that consideration needed to be given to the individual needs of people receiving care and the individual characteristics of the service.

410. Striking the balance between protecting vulnerable care home residents from the virus and allowing them to maintain contact with family and friends was extremely challenging. The provisions of the guidance documents that I have just outlined were intended to encourage providers to respond on a case-by-case basis – taking into account the needs of the individual, the ability of the care home to facilitate visits, and the wider restrictions in place at any given time – rather than operating a 'blanket' policy that had no scope for any flexibility. I recognise that in certain very challenging periods of the pandemic (in particular, the period after the end of the firebreak on 9 November 2020), some care homes did in fact operate what appeared to be rigid policies and took restrictive approaches to visits, even though the national restrictions at the time were more relaxed and permitted a certain level of routine indoor visits. This was a concern throughout the pandemic, and we tried to address the issue by

engaging with the sector. As set out above, I sent a number of letters that reminded providers of the importance of avoiding an unnecessarily restrictive, 'blanket' approach, and this was repeated in the Coronavirus Control Plan: Alert Levels in Wales for Social Care Services. Care Inspectorate Wales also assisted with this, by contacting care homes and giving the same reminders whenever it or the Welsh Government was made aware of specific providers adopting restrictive approaches.

Access to emergency care, NHS support and visits by professionals

411. I am also asked to comment on Covid-19's impact on the extent to which individuals living in adult social care settings could access emergency care, NHS support, and visits by professionals, during the pandemic. Each iteration of the guidance I have set out applied to visits from professionals (including health professionals) and from family and loved ones. Further, as I have referred to, each iteration of the guidance also made provision for indoor visits to take place in exceptional circumstances, even during periods when the general restrictions in force across Wales prohibited any indoor meetings between people not from the same household. This included visits from medical professionals.

412. The pandemic significantly affected adults living in care homes, including access to emergency care, NHS support, and visits by healthcare professionals. Like with the rest of the UK, access to hospitals was highly restricted to prevent the spread of the virus and manage the surge in Covid-19 cases. Many individuals in care settings experienced delays or were unable to be transferred to hospitals for emergency care and hospitals prioritised Covid-19 patients and the need to manage hospital capacity. The adoption of telehealth services was prominent in Wales, with remote consultants becoming a primary means of delivering medical care. This shift aimed to reduce the risk of virus transmission while ensuring continuity of care. However, there remained challenges with digital literacy and the suitability of remote consultants for complex medical conditions.

413. The NHS had to allocate resources and prioritise care for Covid-19 patients, and by doing so, often delayed routine care and elective procedures. This led to longer waiting times for non-Covid-19-related treatments. To protect vulnerable populations, in-person visits by healthcare professionals, such as GPs and specialists, were

significantly reduced. When visits were necessary, stringent infection control measures were implemented, including the use of PPE, regular testing, and strict hygiene protocols.

414. In situations where emergency care was required, care homes had to establish protocols to manage suspected or confirmed Covid-19 cases. This often involved setting up isolation areas within the facilities, training staff in emergency response specific to Covid-19 and coordinating closely with local health authorities.

415. The reduction in visits and the shift to remote care most certainly impacted the mental health and well-being of residents, with the lack of face-to-face interaction with healthcare professionals and family members leading to increased feelings of isolation and anxiety. Staff in adult social care settings also faced increased pressure and challenges in delivering care. They had to balance the need to protect residents from Covid-19 with the need to provide medical and emotional treatment and support.

416. Despite these challenges, we witnessed many care settings adapting rapidly by adopting new technologies, training staff in new protocols and developing innovative methods to maintain quality of care and resident engagement. The increased use of digital health tools, virtual social activities and support and enhanced infection control measures were just some of the strategies deployed. The pandemic forced significant and fast-paced transformation in how medical care was accessed and delivered in adult social care settings. Though remote consultations and strict infection control measures helped mitigate the spread of the virus, they also presented challenges that impacted the quality of care and the wellbeing of residents. The experience highlighted the need for adaptable and robust healthcare systems that can shift and respond quickly in the face of public health crises.

Capacity of social care settings to manage visits

417. Clearly provider capacity, as well as willingness, to support and manage visits safely was essential, and this was always at the forefront of discussions on this issue. I was acutely aware from my own discussions with sector representatives how challenging it was. Through my team in Social Services and Integration, I supported providers with clear and timely guidance and messaging which recognised practical factors such as staff capacity and the size and layout of a care home. The launch of the visitor pod pilot in November 2020 (referred to in paragraph 393 of this statement)

recognised that not all care homes would have sufficient space to facilitate indoor visits, even when wider restrictions allowed. The Welsh Government also introduced lateral flow testing for visitors to care homes in December 2020.

418. In March 2021 the then Deputy Minister announced a pilot project with Age Cymru to develop volunteering in care homes to help support visiting and social contact between residents and relatives, which led to the publication of a toolkit for volunteering in care homes: **AH2/255-INQ000498698**.

Steps taken by the Welsh Government to ameliorate the impact on the lack of visits on recipients of care

419. On 27 March 2020 (days after the national lockdown was introduced), the Minister for Health and Social Services received advice seeking his agreement to an award of £553,000 to the Digital Priorities Investment to extend a Device Loan Scheme operated by the Wales Co-operative Centre. I exhibit it at **AH2/273-INQ000136772**.

420. I understand that the Device Loan Scheme was a pre-existing scheme which loans out devices to public bodies and third sector organisations to use with their clients. The proposal was to extend the scheme to include care homes and wards as recipients of the scheme, to reduce loneliness and isolation by enabling care home residents to keep in touch with friends and family online. The advice further noted that the proposed allocation of 1,100 devices (50 per local authority) was an estimate by the programme, but officials anticipated that demand would outstrip supply. The recommendation was agreed by the Minister on 2 April 2020, email confirmation exhibited at **AH2/274-INQ000498715**.

421. On 6 July 2020, officials from the Education and Public Services Group provided an update on the scheme, which is exhibited at **AH2/275-INQ000498681**. It noted that as of 6 July 2020, Digital Communities Wales had delivered 1,009 devices (of the 1,100 procured) to 559 care homes across Wales and had provided training to over 350 frontline staff to support residents' use of the devices. Work had also taken place in partnership with Technology Enabled Care Cymru to support care homes in accessing the Attend Anywhere virtual GP service, which included training for over 200 care homes which use the service. A subsequent update on 2 September

confirmed that 1,050 devices had been delivered to 584 care homes across Wales: **AH2/276-INQ000235760**.

422. As referred to earlier, Ministers announced on 23 November 2020 the launch of the pilot of the visitor pods scheme. This followed Ministers' agreement to advice submitted on 18 November 2020, exhibited above, asking for agreement to provide £3 million funding which would enable the Welsh Government to lease approximately 100 temporary modular units which could be made available to care homes in Wales for a six-month period. The advice noted the increasing concern about the significant impact that prolonged separation from loved ones was having on residents' mental and physical well-being. The proposed temporary modular units represented a means of quickly enabling visits to care homes. The advice further noted that officials had engaged with Public Health Wales to develop criteria for the specification to ensure that the pods were as Covid-19-secure as possible.

423. On 17 December 2020 the Welsh Government issued a press release confirming that the first visiting pods had been delivered that week, to a residential care home in Llandrindod Wells, and that almost 80 units would be installed and ready for use before Christmas 2020. I exhibit the statement at **AH2/277-INQ000496066**. The scheme continued into the new year, and by March 2021 the Welsh Government had provided 100 visiting pods, free of charge, to care home providers for the six-month hire period. It had also funded the hire of 55 visiting pods via the Local Government Hardship Fund for providers choosing to make their own arrangements, as confirmed in the final update on the Care Homes Implementation Plan issued on 24 March 2021 and exhibited at **AH2/056-INQ000350310**. Although some positive feedback was received on the pods from care home providers, the scheme was not extended beyond the initial six-month hire period as indoor visits had resumed in March 2021.

424. As well as this, the creation of "support bubbles" or "extended households," enabling single adult households or single parents with children under 18 to form a bubble with another household, helped reduce the isolation for some care home residents. The Welsh Government also supported various well-being initiatives aimed at addressing the mental health impacts of isolation, including the provision of funding for mental health services and support for activities that could be safely carried out within care settings.

425. Local authorities and care providers were given flexibility to adapt guidelines to the specific needs of their communities and facilities, which allowed for more tailored approaches that could better meet the needs of people living in care homes, and campaigns were conducted to raise awareness of the importance of maintaining social connections, even remotely, and to provide information on how to use digital tools to stay connected.

Decisions and key guidance regarding the Social Care Workforce

426. I am asked to set out the key decision making and the development of policy and guidance regarding issues concerning the adult social care workforce, including those providing unpaid care in the home, including risks of infection, long term sequelae and death, and disproportionate impacts with regard to Ethnic Minority staff and women.

Covid-19 Workforce Risk Assessment Tool

427. One key measure in this area was the development of a workplace risk assessment tool for use by NHS and social care staff, designed to assess the risk posed to individual NHS and social care staff in their workplaces, so that those risks could be properly managed. In particular, the risk assessment tool took into account and reflected the higher risk that might be posed to individual workers by reason of factors such as their age, sex, ethnicity, and underlying health conditions.

428. The risk assessment tool was developed by the Risk Assessment sub-group of the First Minister's Black, Asian, Minority Ethnic Covid-19 Advisory group, which was convened on 29 April 2020 in response to the concerns that people of some ethnic groups were disproportionately impacted by Covid-19, with consequent adverse health outcomes.

429. The Risk Assessment sub-group was chaired by Professor Keshav Singhal, and I exhibit its Terms of Reference as **AH2/278-INQ000350682**.

430. The Risk Assessment tool that was developed by the sub-group was reviewed by the Chief Medical Officer (Wales) and Dr Andrew Goodall. The Risk Assessment Tool was published online on 26 May 2020, and the First Minister issued a Written Statement that day confirming that the tool had been introduced to the NHS and social

care. Guidance and Frequently Asked Questions were also issued. The final version of the Risk Assessment Tool is exhibited as **AH2/279INQ000023242** and the associated guidance as **AH2/280-INQ000082689**. It was widely used throughout the pandemic.

431. A social care implementation sub-group was convened to help ensure the social care sector was engaged in the work of the First Minister's Covid-19 Advisory Group to address the disproportionate impact of the pandemic on Black, Asian and Minority Ethnic communities, and to support implementation of the risk assessment tool in the social care sector workforce. I exhibit the Terms of Reference of the social care implementation sub-group as **AH2/281-INQ000350559**. Its purpose was to:

- Gather and share evidence from a social care perspective and to support the First Minister's Covid-19 Black, Asian and Minority Ethnic Advisory Group;
- Ensure the application of the workplace risk assessment for frontline social care workers in Wales;
- Monitor the workplace risk assessment tool, its use, and to share concerns with the advisory group;
- Suggest practical steps to mitigate the risk for the staff identified as vulnerable in the social care sector; and
- Consider the evolving evidence and implications for the wider community.

432. The sub-group was chaired by Andrea Street and was attended by a range of stakeholders, including representatives of trade unions, social care providers and the Welsh Local Government Association, as well as Welsh Government officials from the Health and Social Services Group, and a representative of the Care Inspectorate Wales.

433. The sub-group met for the first time on 29 May 2020, following the publication of the Risk Assessment Tool on 26 May 2020. It initially met weekly, then fortnightly, throughout 2020. I exhibit the note of the first meeting at **AH2/282-INQ000514846**. I exhibit a summary of the group's work at **AH2/283-INQ000514866**. This included but was not limited to the following:

- Analysing the impact of Covid-19 on Black, Asian and Minority Ethnic social care workers;
- Encouraging feedback about the sector response;

- Providing options for the implementation and use of the workplace risk assessment tool in the sector;
- Contributing to Frequently Asked Question documents and guidance, where appropriate, to ensure that these were made relevant to the social care sector;
- Ensuring that data was collected from the social care workforce, including data regarding vulnerable care workers.

NHS Wales & social care wellbeing support line

434. Another key measure was the NHS in Wales and social care wellbeing support line. In July 2020, the Minister for Health and Social Services agreed to award funding of up to £110,104 for the Samaritans to deliver targeted and dedicated support for the health and social care workforce in Wales. The helpline was launched on 13 August 2020 and offered anyone working in or with social care (and the NHS) in Wales access to a confidential support line during the pandemic. The support line was accessible to workers every day from 7am to 11pm for English language support and from 7pm to 11pm for Welsh language support and was available to support workers who were feeling worried or overwhelmed.

435. The support line was publicised by Social Care Wales using its networks with care managers and the social care workforce, ensuring social care workers could access the service.

436. As at August 2021, 362 calls had been received during the support line's operating hours, of which 251 were answered (unanswered calls either being abandoned by the caller, the caller being barred from using the helpline, or for reasons unknown).

437. The support line was developed as an initiative of the Health and Wellbeing subgroup of the Workforce Cell, the Terms of Reference of which are exhibited at **AH2/284-INQ000355790.**

Staff movement and risk of transmission

438. Also, in relation to issues affecting the adult social care workforce, including those providing unpaid care in the home, I am asked to set out key decision making and development of policy and guidance in relation to staff movement and the risks of transmission. Although by 18 March 2020, Care Inspectorate Wales had made a

decision to suspend inspections in care homes, the Welsh Government was not in a position to prevent the movement of carers between care homes because of the pressure on the sector – care homes would not have had enough capacity to provide care and support to people if we had prohibited the movement of carers between homes, and we would not have been able to implement the discharge guidance. All of these decisions were difficult, multi-factorial decisions that involved assessment of evidence, risk and priorities.

439. On 6 May 2020 the Technical Advisory Group issued a consensus statement on care homes, exhibited at **AH2/285-INQ000336503**. It stated that care homes were likely to have a high degree of internal transfer of infection, due to the mobility and unpredictability of patients. It recorded that a limited study by Public Health England which pointed to care staff who worked in more than one care home as a significant infection vector. It stated that mobility of care staff between homes should be prevented if at all possible. It also stated that a study in New York found that the majority of those in care homes who were asymptomatic and positive were symptomatic within 5 days. However, we were still not in a position to prevent the movement of carers between care homes because this would have meant inadequate staffing across the sector and would likely have resulted in the sector being unable to deliver basic levels of care due to the limited workforce at that time - caused by staff shielding, sickness absence, and childcare duties.

440. Also, on 6 May 2020 the Technical Advisory Cell met and the minutes, exhibited at **AH2/286-INQ000336505**, record that the care home consensus statement was discussed, in particular in the context of consideration of the provision of testing in care homes (addressed in more detail in paragraphs 510-523 of this statement). It was recorded that, as well as testing, mobility between different care homes was also important in order to catch outbreak spread. Ideally, guidance would be that staff should be restricted to a single care home. However, there were considerable implications on the adequacy of care if this were to be enforced and it would likely have resulted in the sector being unable to deliver basic levels of care due to the limited workforce as a result of shielding requirements, sickness absence, and childcare responsibilities. In December 2020/January 2021 Social Care Wales published advice supporting mutual aid to enable staff movement between neighbouring local authorities for this reason. It is important to understand that in terms of practice it was an extremely challenging period and making such a professional judgement was crucial to ensuring the sector could continue providing even a basic

level of service in caring for the most vulnerable. Making such a professional judgement was also crucial to ensuring the sector could continue caring for the most vulnerable and to potentially avoid an even greater harm, reflecting the ongoing need to balance the ability of the sector to provide care whilst making every effort to protect vulnerable people.

441. By August 2020 the Welsh Government was able to advise on the restriction of movement of staff within social care settings. On 17 August 2020 I wrote to local authorities, Directors of Social Services, and managers of Adult Care Homes, outlining the guidance whilst acknowledging that social care settings had been taking a range of actions to minimise the movement of staff since the beginning of the pandemic, exhibited at **AH2/287-INQ000509286**.

Decisions relating to infection prevention and control ("IPC") measures in the adult social care sector, including PPE

Pre-pandemic stock supplies available to the adult social care sector and sourcing of PPE during the pandemic

442. Providing appropriate and high-quality PPE was one of the most significant challenges in ensuring the safety and well-being of the health care and social care workforce throughout this period. Social Services and Integration Directorate was involved in the establishment and implementation of specific measures to ensure that sufficient and adequate PPE was available to the sector, as I set out in more detail below.

443. Social Services and Integration Directorate is not usually involved in the arrangements for the provision of PPE to the sector, because in ordinary circumstances, it is the individual care providers that are responsible for obtaining their own PPE. By contrast, the Welsh Government's pandemic influenza stockpile of PPE is set up to provide for the social care workforce as well as the NHS workforce, in the event of a pandemic.

444. The Welsh Government's pandemic influenza stockpile of PPE was established in accordance with the agreement made under the UK Pandemic Influenza Strategy 2011

(**AH2/288-INQ000102974**[20]), which operates on a four-nations basis. As part of this stockpile, the Welsh Government maintains a range of medical countermeasures and consumables to deliver what the 2011 strategy termed "a defence-in-depth" pandemic response. The Welsh Government is part of a UK health countermeasures structure that maintains these countermeasures in a state of readiness. All four UK nations hold stockpiles of antivirals, antibiotics, consumables and personal protection equipment for front line health and social care staff.

445. A Memorandum of Understanding was entered into on 18 July 2018 between the devolved governments and the Secretary of State for Health (acting via Public Health England) in relation to the provision of procurement, storage and distribution services forming part of the Pandemic Influenza Preparedness Programme and the Emergency Preparedness Resilience and Response Programme. Included in the Memorandum of Understanding is the procurement, storage and distribution of consumables which broadly includes surgical facemasks, eye protection, liquid hand soap, aprons and gloves. A copy of this Memorandum of Understanding is exhibited in **AH2/289-INQ000177454.** When I refer to a "four nations basis" in relation to PPE I am referring to these arrangements.

446. Under the Memorandum of Understanding, the UK acts as lead purchaser and undertakes procurement exercises on behalf of the four nations to ensure value for money and to enable governments to benefit from economies of scale. On 10 December 2019, the Minister for Health and Social Services agreed to continue the Memorandum of Understanding to 2025. A copy of the Ministerial Advice on the continuation of this agreement is exhibited in **AH2/290-INQ000177473**.

447. Where possible, Wales's proportion of health countermeasures are stored in Wales, in a new, modern, secure location owned by the Welsh Government, and maintained under a Service Level Agreement with the NHS Wales Shared Services Partnership (which is an independent organisation with responsibility for carrying out procurement on behalf of all NHS bodies in Wales, including for PPE). A copy of this agreement is provided in exhibit **AH2/291-INQ000204701**. This location ensured that the stocks could be made available quickly in the event of a pandemic. It also provided value for money through reduced rental and maintenance costs. Due to the scale of countermeasures stock

[20] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000177116]*

managed during the Covid-19 pandemic, I understand additional storage facilities were also used.

448. The Welsh Government's Health Countermeasures Group provided oversight of the national stockpile, which included antiviral medicines, antibiotics, intravenous fluids, a range of medical consumables, and PPE (including surgical masks, eye protection, liquid hand soap, detergent, hand hygiene, clinical waste bags, paper towels, aprons, and gloves). The pandemic influenza stockpile of PPE was crucial during the first four months of the Covid-19 response, before ongoing PPE supplies could be secured.

449. From February 2020, members of this group sat as a weekly Covid-19 Health Countermeasures Group. The Group, reporting into the Health and Social Services Group Covid-19 Planning and Response Group, was chaired by the Health Emergency Planning Adviser, and included the NHS Wales Shared Services Partnership as well as pharmacy and infection control expertise, and representation from my directorate. The Terms of Reference for the group, as exhibited in **AH2/292-INQ000107110** sets out it purpose as to:

    a. Ensure pandemic stocks are deployed according to ministerial agreement.

    b. Consider other demands for release of the stock and advise accordingly.

    c. Monitor resilience of business-as-usual stocks and identify issues to be addressed.

    d. Consider the use of Brexit supplies to reinforce the response to Covid-19.

    e. Ensure that members of the Group worked with UK countries and supply networks.

450. The group developed arrangements to distribute pandemic stock to health services when necessary. Oversight and accountability for this work came under the Health and Social Services Planning and Response Group. The Welsh Government suspended the Health Countermeasures Group on 1 June 2020 as it was superseded by the PPE Cell, described in more detail below.

451. In terms of the pre-pandemic stockpile figures before March 2020, this information would be held by the NHS Wales Shared Services Partnership. The Health

Countermeasures Group received updates on the PPE stock holding, and the reports prior to 9 March 2020 (when formal reporting commenced) are outlined below:

i. 26 February 2020 – **AH2/293-INQ000352951**

ii. 4 March 2020 – **AH2/294-INQ000352953**

452. As of 4 March 2020, the figures were as follows:

PPE Stock as of 4 March 2020

Item description	In date stock held	Out of date stock held	Total stock held
APRON DISPOSABLE POLYTHENE (ROLL 200)	45,649	0	45,649
BAG CLINICAL WASTE YELLOW (ROLL 150)	0	0	0
BAG CLINICAL WASTE ORANGE (ROLL 25)	9,919	0	9,919
EYEWEAR: GOOGLES PROTECTIVE FRAMES PG0001F	1,488,000	0	1,488,000
EYEWEAR: GOOGLES PROTECTIVE LENSES PG0001L	1,656,000	0	1,656,000
FACEMASK RESPIRATOR FFP3 UNVALVED: 1863	0	559,080	558,080
FACEMASK RESPIRATOR FFP3 VALVED: 1873V	0	64,680	64,680
FACEMASK RESPIRATOR FFP3 VALVED: 8833	0	246,240	246,240
FACEMASK RESPIRATOR FFP3 VALVED: 8833 (ADDITIONAL FROM NHS ENGLAND)	77,520	0	77,520
FACEMASK TYPE IIR SURGICAL: SFM001	4,906,000	0	4,906,000
GLOVES NITRILE LARGE (PACK OF 200): GN92L	5,490	0	5,490
GLOVES NITRILE MEDIUM (PACK OF 200): GN92M	10,520	0	10,520
GLOVES NITRILE SMALL (PACK OF 200): GN92S	8,060	0	8,060
VENTILATOR ADULT (PNEUPAC)	27	0	27
VENTILATOR CHILD (PNEUPAC)	9	0	9
LIQUID ALCOHOL HAND RUB 0.5L	23,880	0	23,880
LIQUID HAND SOAP (GEL) 0.5L	0	0	0
LIQUID HAND SOAP (FOAM) 0.5L	0	0	0

NEUTRAL DETERGENT 1.0 LITRE (HOSPEC)	13,446	0	13,446
HANDTOWELS 2PLY ZIGZAG FOLDED 23C25CM: MTR041	87,000	0	87,000
SHARPS CONTAINED 22L: DD475YL	1,404	0	1,404
SURGICAL GOWNS	0	0	0

453. A combined report setting out management information received from the NHS Wales Shared Services Partnership on PPE items issued during the pandemic period up to 27 March 2022 is exhibited in **AH2/295-INQ000227378**.

454. During the pandemic, the pre-existing pandemic stockpile in Wales was supplemented by NHS Wales Shared Services Partnership, which procured and distributed additional PPE on behalf of the Welsh Government. From March 2020, the NHS Wales Shared Services Partnership rapidly expanded its existing NHS-only supply and distribution process for health boards, to one that supplied PPE to local authorities for onward distribution to the social care sector, as well as delivering to primary care settings including GPs, pharmacists, and dental and optometry contractors, as outlined by the Minister for Health and Social Services in a Written Statement published on 19 March 2020 as exhibited in **AH2/296-INQ000383574**.

The PPE Cell

455. In addition to the Welsh Government's Health Countermeasures Group, an 'executive leads group', referred to as the 'PPE cell', met from late April 2020 and brought together a senior officer from the Welsh Government, Alan Brace (Director of Finance), and representatives from the NHS Wales Shared Services Partnership, each health board, Velindre NHS Trust, Welsh Ambulance Service Trust, and Public Health Wales, to exchange information on local issues and the national response. This group initially supplemented the Covid-19 Health Countermeasures Group referred to above, eventually replacing it from June 2020. The creation of a standalone PPE Cell and having an executive director chairing the group provided prominence and leadership in relation to PPE.

456. The PPE Cell was tasked to undertake three things, firstly to review the sourcing of PPE for Wales, to consider the stockpiling of PPE, and to assess the arrangements for the distribution of PPE across Wales for both the health and social care sectors. These three things were multifaceted and required working with a number of organisations.

457. The Welsh Government also worked closely with the Welsh Local Government Association via a Covid-19 procurement working group which was established on 23 March 2020 and met daily. The working group brought together local government procurement leads with Welsh Government officials. The NHS Wales Shared Services Partnership joined this group from 9 April 2020, ensuring a joined-up approach to procurement of PPE across health and social care in Wales.

458. The PPE Cell reported regularly to Andrew Goodall and also provided assurance to the Minister for Health and Social Services. It also liaised with the Deputy Minister for Economy, Lee Waters, to support the Welsh manufacturing of PPE.

459. Between March 2020 and March 2022, the NHS Wales Shared Services Partnership issued over 1.3 billion items of PPE to the health and social care sectors in Wales. About 550 million of these were issued to the social care sector. The data includes PPE procured directly by the Shared Services Partnership as well as PPE received from the UK Government as part of the four nations arrangements. This does not include any stock procured directly by local authorities.

Formulation of infection prevention and control measures within adult social care settings during the pandemic

460. During all phases of the Covid-19 pandemic, the UK infection prevention and control guidance was available to health and social care providers in Wales. The guidance was based on a continuous review of the international evidence base and was issued jointly by the UK Department of Health and Social Care, Public Health Wales, the Public Health Agency (Northern Ireland, Public Health Scotland, UK Health Security Agency ("UKHSA") and NHS England, referred to as the 'UK IPC Cell'.

461. The UK IPC Cell was set up in January 2020 and Wales's involvement was led throughout by Public Health Wales. Dr. Eleri Davies, Head of Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme ("HARP") at Public Health Wales and Dr. Anna Louise Schwappach, Specialty Registrar in Public Health, also of Public Health Wales.

462. The infection prevention and control guidance for the UK, including Wales, was issued by the UK Government on 10 January 2020 and based on the limited information available at that time about the coronavirus. The Chief Medical Officer (Wales) wrote out

to all clinical staff in Wales on the 24 January 2020 providing a link to the UK Government website where the infection prevention and control guidance was located. A copy of this letter is provided in exhibit **AH2/297-INQ000224481**[21]. This guidance was updated throughout the pandemic period. The Welsh Government did not keep a log of the updates or changes to the guidance as this was held by the UK Government. I understand that all iterations of the infection prevention and control guidance were adopted in Wales as they became available.

463. A key source of guidance and oversight of infection prevention and control measures in Wales was via the Nosocomial Transmission Group. The Deputy Chief Medical Officer (Wales) and the Chief Nursing Officer for Wales established the Nosocomial Transmission Group in May 2020. Its first meeting was held on 19 May 2020. The Group's membership was drawn from the Welsh Government (including policy leads from Social Services and Integration Directorate), Public Health Wales, and colleagues from health, social care and professional organisations. The group was stood down on the 28 March 2022.

464. The purpose of the Nosocomial Transmission Group was to provide advice, guidance and leadership for all healthcare and care settings, including care homes, domiciliary care, and learning disability units, to minimise nosocomial transmission and enable the safe resumption of services.

465. The Nosocomial Transmission Group and Nosocomial Policy team worked with stakeholders to develop a range of guidance, including on implementing infection prevention and control measures, PPE, Covid-19 testing, cleaning standards, bed spacing, ventilation and environmental controls – including some guidance for social care settings. A list of 'Guidance issued in association with Nosocomial Transmission Group work' is provided in exhibit **AH2/298-INQ000227417**. A number of these documents were issued jointly or wholly by agencies such as Public Health Wales and the NHS Wales Shared Services Partnership rather than the Welsh Government.

466. The Nosocomial Transmission Group provided regular updates to the Chief Medical Officer (Wales) and the Planning and Response group, which assessed the implementation of infection prevention and control measures in health and social care settings in Wales. A copy of the update report issued on 15 November 2020 is exhibited

[21] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000226917].

in **AH2/299-INQ000396261**, and a further report issued 18 February 2021 which is exhibited in **AH2/300-INQ000227307**.

467. In relation to PPE specifically, guidance was agreed jointly between the four UK nations and was set out in the UK PPE Plan and on the UK-wide Covid-19 PPE hub, which included recommendations on the use of PPE for health and social care settings. The guidance was written and reviewed by all four UK public health bodies and informed by NHS infection prevention control experts. The guidance was consistent with World Health Organization guidance for protecting health and social care workers from Covid-19.

468. On 2 April 2020 updated UK-wide PPE guidance was agreed by the four UK Chief Medical Officers, Chief Nursing Officers and Chief Dental Officers in the UK and endorsed by the Academy of Medical Royal Colleges. This guidance was maintained by the UK Government online and applied to healthcare settings and community care settings, including care homes. I exhibit a copy of:

i. Covid-19 Infection Prevention and control guidance **AH2/301-INQ000088334**

ii. A separate copy of the specific PPE section – **AH2/302-INQ000352974**

iii. New PPE Guidance for NHS Teams summary – **AH2/303-INQ000336373**

iv. Table 2 (reproduced below) – Recommended PPE for primary, outpatient and community care by setting, including care homes – **AH2/304- INQ000352976**

v. Table 3 (reproduced below) – Additional considerations in addition to standard infection prevention and control precautions, where there is sustained transmission of Covid-19 – **AH2/305-INQ000352977**

vi. Media Q&A on the guidance **AH2/306-INQ000352980**

469. The guidance provided that in care settings, including care homes, with a confirmed or suspected case of Covid-19, anyone giving direct care within two metres of a resident should wear surgical gloves, plastic apron, type IIR surgical mask, and eye/ face protection.

Table 2: Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

1. This may be single or reusable face/eye protection / full face visor or googles

		Recommended PPE						
Setting	**Context**	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/ gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non-emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ Single or sessional use[4,5]	✗	✓ Single or sessional use[4,5]
	Working in reception / communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ risk assess single or sessional use[4,5,8]
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding[9]	✓ single use[4]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✓ single use[4]	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Community-care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s)[3] – and direct resident care (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ sessional use[5]	✗	✓ risk assess sessional use[4,5]
Any setting	Collection of nasopharyngeal swab(s)	✓ single use[4]	✓ single or sessional use[4,5]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Ambulance staff/ paramedic/ first responders/ pre-hospital critical care/ Helicopter Emergency Medical Service/ hospital transport services	Performing an aerosol generating procedure e.g. intubation, suctioning[2] on possible or confirmed case(s)[3]	✓ single use[4]	✗	✓ single use coverall[4]	✗	✗	✓ single use[4]	✓ single use[4]
	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single use[5]	✗	✓ single use[5]
	Driver conveying possible or confirmed case(s)[3] in vehicle with a bulkhead, no anticipated direct care[10]	✗	✗	✗	✗	✗	✗	✗
	Driver conveying possible or confirmed case(s)[3] in vehicle without a bulkhead, no direct patient care and within 2 metres[10]	✗	✗	✗	✗	✓ single or sessional use[4,5]	✗	✗
Pharmacy	Working in an area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
	Working in an area with possible or confirmed case(s)[3] and able to maintain social distancing	✗	✗	✗	✗	✗	✗	✗

1. This may be single or reusable face/eye protection / full face visor or googles.
2. The full list of aerosol generating procedures (AGPs) is within the IPC guidance. [note APGs are undergoing a further review at present]
3. A case is any individual meeting case definition for a possible or confirmed case. https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/ exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting / exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2m social distance on entering, where the health or social care worker assesses that an individual is symptomatic with suspected /confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated /likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
10. In communal waiting areas and during transportation, it is recommended that possible or confirmed cases wear a surgical face mask if this can be tolerated. The aim of this is to minimise the dispersal of respiratory secretions, reduce both direct transmission risk and environmental contamination. A surgical facemask should NOT be worn by patients if there is potential for their clinical care to be compromised (e.g. when receiving oxygen therapy via a mask).

Table 3. Additional considerations, in addition to standard infection prevention and control precautions, where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

		Recommended PPE						
Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/ gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/ face protection[1]
Any setting	Direct patient/ resident care assessing an individual that is not currently a possible or confirmed case[2] (within 2 metres)	✓ single use[3]	✓ single use[3]	✗	✗	✓ risk assess sessional use[4,5]	✗	✓ risk assess sessional use[4,5]
Any setting	Performing an aerosol generating procedure[6] on an individual that is not currently a possible or confirmed case[2]	✓ single use[3]	✗	✓ single use[3]	✗	✗	✓ single use[3]	✓ single use[3]

1. This may be single or reusable face/eye protection / full face visor or googles
2. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
4. Risk assess refers to utilising PPE when there is an anticipated /likely risk of contamination with splashes, droplets or blood or body fluids. **Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/ single session.**
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/ exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting / exposure environment. Sessional use should always be risk assessed and consider the risk of infection to and from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The full list of aerosol generating procedures (AGPs) is within the IPC guidance. [note APGs are undergoing a further review at present]

470. The updated guidance reflected the fact that Covid-19 was now widespread in the community. It was based on the best scientific evidence and was consistent with the recommendations of the World Health Organisation. The Chief Medical Officer (Wales) wrote out to bodies in the NHS in Wales informing them of the update on the 3 April 2020. A copy of this letter is exhibited in **AH2/308-INQ000080942** along with the appendices set out in **AH2/309-INQ000080940, AH2/310-INQ000117822**[22] and **AH2/311-INQ000080939.**

471. I am asked to explain the extent to which scientific evidence led to changes in infection prevention and control measures within the adult social care sector. In the Welsh Government, our approach to any policy is to work in collaboration with key stakeholders, using relevant and up to date evidence and research (including that of Public Health Wales, the Technical Advisory Cell and SAGE) to provide advice to ministers on the policy in question through formal, routine advice procedures. The Welsh Ministers' role is then to agree and set the policy direction, bring together partners and co-ordinate activity across Wales, and agree funding. Throughout this period, we were largely reliant

[22] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000080941]

on information from Public Health Wales as to the most effective measures to prevent or control Covid-19 infections.

Decision making relating to the provision of PPE to the adult social care sector during the pandemic

472. In early March 2020, work began within Social Services and Integration Directorate to identify possible solutions for the supply and distribution of PPE for the social care sector. At this time, the directorate was already starting to receive queries from some local authorities who were experiencing difficulties obtaining PPE, and officials were keen to ensure that the needs of the social care sector were taken into account in the arrangements that were already underway for the provision of PPE to the healthcare sector. Andrea Street directed the head of the social care co-ordination hub and others from Social Services and Integration Directorate to lead on this, and they in turn liaised with the Health Emergency Planning Unit, which was by that time already meeting regularly. The NHS Wales Shared Services Partnership had in fact already provided to the Welsh Government, on 18 February 2020, a list of the 22 local authority social services delivery locations, which had been developed as part of EU Exit planning, should the Welsh Government need to supply PPE to the social care sector. On 9 March 2020, this list was passed to an official in my directorate, **AH2/312-INQ000470674**.

473. On 16 March 2020, a member of my team attended the weekly meeting of the Health Countermeasures Group, when it was agreed that the NHS Wales Shared Services Partnership would provide the social care sector with PPE from a central contingency supply, under a social care distribution structure that would be established and implemented by the Welsh Government. Under this distribution structure, local authority Social Service Directors would receive the stock to be distributed by the NHS Wales Shared Services Partnership at the relevant local authority delivery points, for onward distribution to social care providers. The Chair of the Health Countermeasures Group sent an email the day after this meeting, on 17 March 2020, confirming that the social care distribution structure would need to be in place by 19 March 2020, **AH2/313-INQ000299018**. The NHS Wales Shared Services Partnership provided confirmation to the Welsh Government of the PPE it would be able to provide, which included disposable gloves, disposable plastic aprons, fluid resistant surgical masks type IIR, and protective glasses, **AH2/314-INQ000470675**.

474. On 17 March 2020, there was discussion about the possibility of PPE being distributed via local health boards until the social care distribution structure was fully operational: **AH2/315-INQ000470680**. In the same email thread, Public Health Wales circulated to Welsh Government officials the first draft of the PPE guidance for social care settings, **AH2/316-INQ000470681**. It recommended the following PPE for the care of those with acute respiratory infection (ARI) or flu-like illness:

i. Fluid Resistant Surgical Mask (FRSM);
ii. Disposable gloves;
iii. Disposable plastic apron;
iv. Appropriate eye protection after risk assessment of need if splashing or spraying of body fluids likely.

475. On 18 March 2020, local health boards were asked, as an interim contingency measure, whilst the social care distribution structure was being developed, to put in place arrangements to support the provision of PPE to social care settings where needed. It was noted that some health boards were already making such provision, **AH2/317-INQ000470733**.

476. On 19 March 2020, I wrote to social care providers confirming that a supply of PPE was being distributed for use by social care settings where staff were providing direct care to anyone suspected or confirmed as having the virus according to the current definition for community cases, either living in their own homes, or in care homes, **AH2/318-INQ000336310**. In that letter, I set out guidance on the circumstances in which PPE should be used and the type of PPE to be used, which was based on the draft advice that had been provided by Public Health Wales on 17 March 2020. This included the statement that if neither the care worker nor the individual receiving care were symptomatic, then no PPE was required above and beyond normal good hygiene practices. I also outlined the interim arrangements for social care providers to approach their local health boards for urgent PPE assistance where needed, if PPE could not be accessed by care providers' normal routes. This letter was forwarded to all care home and domiciliary care providers on 20 March 2020 by Care Inspectorate Wales, **AH2/319-INQ000470682**.

477. Also on 19 March 2020, the Minister for Health and Social Services issued a Written Statement, confirming provision of PPE to social care settings across the whole of Wales, as exhibited above at **AH2/296-INQ000383574**. It noted that stock would be issued at the earliest opportunity, as well as guidance for care providers on how to request access to PPE stock when needed. The Minister also gave the direction as provided in my letter to the sector, that if neither the care worker nor the individual receiving care were symptomatic, then no PPE was required above and beyond normal good hygiene practices.

478. On 24 March 2020 an email discussion took place relating to concerns from local authorities that the volume of supplied PPE was insufficient to meet their needs. The discussion included representatives from the Welsh Government, the NHS Wales Shared Services Partnership, and local health boards. The email exchange is exhibited at **AH2/320-INQ000470683.** This exchange informed the establishment of a delivery schedule as outlined in my letter of 7 April 2020, to which I refer below.

479. A further Written Statement exhibited at **AH2/321-INQ000299063** was issued by the Minister for Health and Social Services on 25 March 2020, outlining the additional steps taken to enhance the supply of PPE to the health and social care sectors, including contingency arrangements for social care providers to access PPE through their local authority Director of Social Services. It noted that revised guidance on PPE had been agreed across all UK nations, and which was consistent with guidance from the World Health Organization.

480. On 1 April 2020, draft updated UK PPE guidance for the health and social care sectors, which had been agreed in principle by the UK Chief Medical Officers (and which contained the tables replicated above), was submitted by the Deputy Chief Medical Officer for Wales to the Minister for Health and Social Services and Andrew Goodall, and copied to me: **AH2/322-INQ000477028** and **AH2/323-INQ000477029**. The email acknowledged that the change in the UK guidance would prove challenging, as much more PPE would be used placing a higher demand on stocks.

481. As there were changes from the existing guidance this was followed up with the NHS Wales Shared Services Partnership. The envisaged increase in demand informed

subsequent actions outlined below. Public Health Wales issued guidance to the social care sector providing support with implementation of the updated UK PPE guidance: **AH2/324-INQ000470699**.

482. On 7 April 2020, I sent a letter to local authority Directors of Social Services, local authority equipment store leads and the Social Care Planning and Response Subgroup confirming the provision of PPE for social care settings over the Easter bank holiday: **AH2/325-INQ000470692**. I also confirmed that a regular timetable for deliveries would be established, to assist in managing stock levels, monitoring usage and reassuring the sector.

483. At around the same time as this, there was discussion regarding the extension of the work being carried out by a Military Assessment Team that had been given responsibility with reviewing the Welsh Government's arrangements for PPE distribution so that this should include the social care sector, as well as healthcare. The Team provided a report on its findings on 21 April 2020 **AH2/326-INQ000470703**, which the Welsh Government circulated to local authority Directors of Social Services, who submitted their own response to the report on 29 April 2020: **AH2/327-INQ000473919** and **AH2/328-INQ000473920**. The Military Assessment Team provided further reports on 19 May 2020: **AH2/329-INQ000500181, AH2/330-INQ000500182, AH2/331-INQ000500183, AH2/332-INQ000500185, AH2/333-INQ000500184, AH2/334-INQ000500186**. These were essentially operational reports aimed at improving the operational procedures that were in place for distributing PPE to the sector.

484. Among the recommendations was the need for centralised basic supply training, to improve supply chain knowledge in the sector. Training on PPE distribution capability was delivered by the Regiment Royal Logistic Corps between 2 and 15 June 2020 across the seven health boards. A report summarising the training is exhibited at **AH2/335-INQ000470719.**

485. On 17 April 2020, I, the Chief Medical Officer (Wales) and the Chief Nursing Officer (Wales) circulated to health and social care providers in Wales a public health link to an alert published by the Medicines and Healthcare products Regulatory Agency notifying of guidance issued by the Chief Medical Officer (England) on 'Considerations for PPE in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic': **AH2/336-INQ000081011**. This was issued in Wales in accordance with

routine practice for Medicines and Healthcare products Regulatory Agency alerts, however the letter assured health and social care providers that this information was not being cascaded because we expected any interruption in our ability to meet PPE demand in Wales.

486. Though the pressures that were experienced regarding the supply of social care PPE in the early days of the pandemic did ease, we continued to receive reports of concerns from the sector into April and May 2020. I exhibit an email that was sent to me by the Association of Social Services Directors on 24 April 2020 **AH2/337-INQ000470701**, and an exchange between Social Services and Integration Directorate officials and the Welsh Government's Director of Finance on 5 May 2020 which recorded that some local authority Directors were still reporting demand as outstripping supply: **AH2/338-INQ000470706**. We also received a letter from Wales Carers Alliance on 16 April 2020 about the lack of guidance for unpaid carers as to how PPE should be accessed and used by them, **AH2/339-INQ000222682**. The head of the Social Care Co-ordination Hub brought this issue to the attention of Public Health Wales later that month, **AH2/340-INQ000500171**, and on 22 May 2020 the Minister for Health and Social Services agreed to the inclusion of unpaid carers in the Welsh Government's arrangements for PPE supply: **AH2/341-INQ000500187**. Following this decision, officials produced and circulated guidance for unpaid carers, which I exhibit as **AH2/342-INQ000470712, AH2/343-INQ000470714, AH2/344-INQ000470713**. I also exhibit the associated Ministerial Advice as **AH2/345-INQ000144919**.

487. In September 2020, the Welsh Government put in place a formal service level agreement between the Welsh Local Government Association and the NHS Wales Shared Services Partnership to provide free PPE for social care within local authority areas, including private, independent and third sector providers. The agreement was signed on 19 September 2020, **AH2/346-INQ000436116**[23], and was subsequently renewed until March 2023, **AH2/347-INQ000470740**.

[23] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000470728]*

Supply and quality of PPE provided to the social care sector

488. I am asked to summarise the supply and adequacy/ quality of the PPE that was provided to the social care sector during the pandemic. In doing so I have drawn on evidence provided to the Inquiry for Module 5.

489. As to the quality of PPE, there was a proper procurement process at the UK level ensuring that products complied with the regulatory standards. Compliance of the PPE products in the pandemic influenza stockpile was determined at the UK level based on scientific evidence with advice from the New and Emerging Respiratory Virus Threats Advisory Group, which included a PPE subgroup on which Public Health Wales represented Wales.

490. Temporary arrangements were adopted in March 2020 following Commission Recommendation 2020/403 ("the Recommendation") which eased the requirement for a conformity assessment for certain categories of PPE for a limited time to increase the supply of essential Covid-19-related PPE on the UK market generally. From March 2020 until 31 January 2021 the Recommendation applied. In practice, this enabled the NHS and the governments of the UK to procure non-conformity assessed PPE for health and care workers, provided the PPE met essential health and safety requirements, as approved by Health and Safety Executive. It also permitted PPE which required a conformity assessment to be placed on the UK market before the full conformity assessment procedures had been completed and before a conformity mark (i.e. "CE" mark) had been affixed. The conformity assessment procedures were however required to be completed as soon as possible afterwards. Therefore, for all PPE in this period procured or introduced to the UK Market, the Health and Safety Executive would have certified that it met essential health and safety requirements.

491. While the PPE Regulation would become retained EU law when the Transition Period ended[24], the Recommendation would lack clarity or legal certainty, and so equivalent provision needed to be made in domestic law. The Welsh Ministers therefore made the Personal Protective Equipment (Temporary Arrangements) (Coronavirus) (Wales) Regulations 2020 because of the pandemic and the UK's exit from the European Union. Similar temporary arrangements were made in England to enable faster supply of PPE for Covid-19 use. These Regulations replicated the arrangements set out in the EU

[24] Amendments in respect of EU Exit were made to the PPE Regulation in Schedule 35 of the Product Safety and Metrology etc. (Amendment etc.) (EU Exit) Regulations 2019

Recommendation. In the Regulations, the arrangements only applied to "Covid PPE" which was defined as PPE that is necessary for protection against the coronavirus disease.

492. In Wales, the NHS Wales Shared Services Partnership worked with the Surgical Materials Testing Laboratory who provided expert guidance, assessment and quality assurance on PPE products manufactured in Wales. These products were of course also under the same requirements as set out in the summary of the legislation above.

493. As to the amount of supply that was available, this remained a paramount concern throughout the pandemic period. Ensuring a continuous and adequate supply was a clear part of the infection and prevention control measures outlined above, and of the safety measures for key workers, including health and social care staff. Additional measures were put in place to help allay concerns, including providing greater visibility of the products available and what was on order. In addition, Deloitte was asked to undertake modelling on future product demands. The Welsh Government's Internal Audit Service undertook a review of the PPE structure within the Welsh Government in December 2020 and confirmed reasonable assurance. A copy of this is exhibited in **AH2/348-INQ000022592.**

494. In April 2021, the Auditor General for Wales issued a report 'Procuring and Supplying PPE for the COVID-19 Pandemic', which provided an independent review of the national efforts to supply health and social care in Wales led by the Welsh Government, working with the NHS Wales Shared Services Partnership and local government. A copy of this is exhibited in **AH2/349-INQ000214235**[25]**.** The report concluded that:

    i. The challenge facing the NHS and social care at the start of the pandemic was stark. Public services across Wales responded in an increasingly collaborative way. Shared Services worked closely with local government to understand demand in social care and took on an increasing role supplying PPE to the sector.

    ii. In March 2020, joint working was not as developed between Shared Services, local government and the social care sector as it was between Shared Services and NHS bodies. This was because Shared Services' core work up until that time had been to supply services delivered directly by health boards and trusts, and it had not previously been responsible for supplying independent primary

[25] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000066526]

care contractors and social care. While the Welsh Local Government Association reported that local authorities did not initially feel sufficiently involved in a collective health and social care response, this changed on 9 April 2020 when Shared Services joined the procurement working group set up between the Welsh Local Government Association and the Welsh Government (referred to above), and collaboration and partnership working was reported to be much stronger than it was in normal times.

iii. By 7 May 2020, it was reported that around two thirds of the social care sector's needs in relation to PPE were being met by the NHS Wales Shared Services Partnership. Between 9 March 2020 and 2 February 2021, the NHS Wales Shared Services Partnership delivered some 630 million items of PPE to the sector; in the period April 2020 to January 2021, around half of this was to social care.

iv. Shared Services data showed that, nationally, stocks did not run out although stocks of some items got very low. At times, Wales drew on mutual aid from other countries but ultimately gave out significantly more than it received. The health and care system (at the date of the report) was in a much better position with buffer stocks of most PPE items in place and orders due on key items where stocks were below target.

v. Overall, Shared Services developed good arrangements to rapidly buy PPE, while balancing the urgent need to get supplies for frontline staff with the need to manage significant financial governance risks in an area of rapidly growing expenditure. These risks included dealing with new suppliers, having to make large advance payments and significant quantities of fraudulent and poor-quality equipment being offered.

vi. Time pressure meant due diligence could not always be carried out to the level it would outside of a pandemic in a normal competitive tendering process, and the requirements under emergency procurement rules to publish contract award notices within 30 days were not met. However, for each contract reviewed, Audit Wales found evidence of key due diligence checks and, while costs were generally higher than before the pandemic, saw evidence of Shared Services negotiating prices down.

Decisions relating to testing within the adult social care sector

495. I have been asked to explain the key decision making and development of policy and guidance regarding testing within the adult social care sector. I addressed earlier in this statement the decisions made regarding the testing of care home residents before discharge from hospital in March and April 2020, in the section entitled Hospital Discharge Decisions. I will now address decisions that were made in relation to testing within the adult social care sector after that time.

496. From a social care perspective my overriding concern was the safety of our most vulnerable people in Wales and those who care for them. For clinical and technical teams, there was still only new or growing evidence in relation to testing, and the problem of false readings. The advice that the Welsh Government was receiving from Public Health Wales was that careful adherence to general infection prevention and control measures (such as social distancing and PPE) were more effective than using testing as a tool to protect people. In terms of the operational perspective, there was only a limited capacity for testing available through the laboratory system and this had to be carefully managed to ensure that it was being used in the most optimal way. Delays in obtaining test results and anecdotally reported false readings for results also had significant impacts on the sector's confidence to rely too heavily on testing. My team and I worked closely and proactively with our colleagues on these issues to ensure that we were able to maximise the testing response in order to keep social care users and their carers safe. At times this meant working our way through challenging conversations.

497. In the early stages it was sometimes difficult to be clear about who was making what decisions for testing and where, and therefore difficult to ensure that social care testing policy was optimal and to ensure that social care needs were considered in the formulation of testing policy. This created some tensions in the early stages of the pandemic. The process to obtain a decision to introduce testing for domiciliary care, which I reference later, is a clear example of this. In order to better inform the decision making process and to improve alignment between clinical, technical, public health, operational and social care policy perspectives for testing in social care settings, in November 2020 I contacted key individuals who were part of the testing response (Tracey Cooper from Public Health Wales, Frank Atherton as Chief Medical Officer

(Wales), and Jo-Anne Daniels as the Welsh Government's Testing Senior Responsible Officer) to make the case for a more coordinated approach. As a result of these discussions, the Social Care, Testing, Infection Prevent and Control Group was established. That group held its first meeting on 16 November 2020, which I chaired, and continued to meet for the remainder of the pandemic response, by which time I handed over the chairing role to the social care testing lead. I exhibit the Terms of Reference for the group as **AH2/009-INQ000198526.**

498. I also ensured that our engagement with the social care sector was proactive, regular and open, to ensure that we could work closely with them to hear and respond to any concerns or risks that were arising for them as the pandemic progressed. This engagement took place through the Health and Social Services Planning and Response Group and the Social Care Planning and Response sub-group, as well as some of our usual forums such as my meetings with local authority Directors of Social Services and with Care Forum Wales. This open and collaborative approach to engagement was welcomed by the sector.

Early stages of implementing the wider testing regime

499. In the early stages of the pandemic, Public Health Wales led on the testing response, working closely with the Chief Scientific Adviser for Health and the key point of contact for the Welsh Government. Following clearance by the Minister for Health and Social Services on 28 March 2020, the Welsh National Covid-19 Test Approach was implemented and subsequently published on 7 April 2020, as exhibited in **AH2/350-INQ000083242.** Public Health Wales provided all the testing capacity in Wales at that time, with only our own domestic laboratory system to rely upon. Public Health Wales worked closely with local health boards to deploy our first testing capabilities. Returning travellers in Wales were tested from 29 January 2020 and testing of front-line staff, as well as inpatients, for the virus (antigen testing) commenced from 7 March 2020.

500. The Welsh Government led a consortium of stakeholders to deliver this first iteration of the national plan for Covid-19 testing. This included Public Health Wales, local health boards, the NHS Shared Service Partnership, NHS Wales Informatics Service, the Life Sciences Hub, Health Technology Wales, the Genomics Partnership Wales and academic partners. The 'National Testing Plan in Wales for COVID-19' was intended to work alongside the UK Testing Strategy that had been announced

on 4 April 2020 by the Secretary of State for Health and Social Care. This stakeholder group was part of the Welsh National Covid-19 Test Plan Task & Finish Group, the Terms of Reference for which is exhibited at **AH2/351-INQ000338227.**

501. In addition, in a step to ensure that the Social Services and Integration Directorate continued to be involved and that social care priorities were fully recognised and prioritised, on 8 July 2020 I appointed Shelley Davies, who at the time was Social Services and Integration Directorate's Head of Partnership and Integration, as the Social Care Testing lead, who worked closely with the central testing team. My aim was to ensure that testing policy was able to respond to the social care sector and to ensure that social care policy was appropriately influencing the shape of testing policy and decisions.

Introduction of testing for care homes

502. On 28 April 2020, the UK Government announced that it would be mass testing asymptomatic care home residents and staff. The initial understanding of this announcement within the Welsh Government was that this meant that the UK Government was intending to test all care home residents and staff, regardless of whether they had symptoms. On the afternoon of 30 April 2020, Public Health England circulated a draft paper setting out the options as to how asymptomatic care home residents and workers who tested positive as part of this mass screening should be treated, and this paper was subsequently circulated to officials within the Welsh Government (including me) and Care Inspectorate Wales. Exhibited at **AH2/352-INQ000500175** is the draft Public Health England paper. Also on 30 April 2020, I requested that Social Services and Integration Directorate officials provide an update on care home testing policy to Andrew Goodall, which I exhibit as **AH2/353-INQ000501509** and **AH2/354-INQ000501510** which referred to the new UK Government policy, as it was understood at that time, to test all residents in care homes whether symptomatic or not.

503. However, at a Senior Clinicians Group (a weekly meeting of the four UK Chief Medical Officers and some other UK Government clinicians) on the evening of 30 April 2020, it became apparent that the UK Government's plan was not to carry out testing of all residents and staff in all care homes – but to carry out testing on a prioritised basis, with staff and residents in a home with a new outbreak first in priority, followed

by testing of the largest Covid-19-free homes (50 beds or more), followed by the next cohort to be determined by local authorities based on risk assessments taking into account number of beds and whether there had been a previous outbreak, and finally other homes with no outbreak and under 50 beds. The Chief Medical Officer (Wales) sent an email to Welsh Government officials, including me, to update them of the discussion at the Senior Clinicians Group meeting on 30 April 2020: **AH2/355-INQ000500209**. I also exhibit the paper setting out the UK Government's plans on testing of care homes which the Chief Medical Officer (Wales) had attached to his update to me and others within the Welsh Government, and which I understand had been discussed at the meeting, **AH2/356-INQ000383855**.

504. Also on 30 April 2020, advice was provided to the Minister for Health and Social Services **AH2/357-INQ000353847** recommending a change in the Welsh Government's policy on testing care home residents and staff. The advice explained that the testing of care home residents alone would require an additional 25,000 tests per week, without factoring in care home staff, and that the scientific evidence at that time did not support a policy of testing of all asymptomatic individuals as being the best use of testing capacity. The evidence instead pointed to the testing of symptomatic people, isolating those individuals until the tests were returned, and in the case of a positive result, assuming that everyone in the care home was positive. There was also a risk with testing asymptomatic people too soon, in that a negative result could create a false sense of security.

505. On that basis, the advice recommended that the new policy for care home testing should be one of targeted testing, relying on mobile testing units, of:

a. All care home residents and staff in homes experiencing outbreaks, with repeat testing the following week; and
b. All care home residents and staff in the biggest homes, meaning over 50 beds, where there was the highest risk of outbreaks.

506. The advice also noted that the position of the UK Government had been clarified that day at the Senior Clinicians Care group (i.e. 30 April 2020), and that there would not be testing of all residents in all care homes in England but rather testing of all care home residents and workers in homes where there was an outbreak. This clarification of the UK Government policy was reiterated by the Chief Scientific Adviser for Health in his email the following morning, 1 May 2020, to Andrew Goodall: **AH2/358-INQ000501512**. I also received an update from a Special Adviser reporting

a discussion that he had had with the Deputy Minister the same morning about care home testing, referring to the logistical difficulties of wider testing but stating that the Deputy Minister wanted to see some enhancement of selective testing: **AH2/359-INQ000501516**.

507. Care home testing was further discussed at a Technical Advisory Group meeting later on 1 May 2020, when it was noted that a consensus statement on care home testing was required: **AH2/360-INQ000336668**. I understand that the Technical Advisory Group considered a paper on testing in care homes from the Welsh Government Office for Science, which I exhibit as **AH2/361-INQ000384716**. In that paper, it was reported that the Minister for Health and Social Services had not been told about the UK Government's intention to offer testing to all are home staff and residents, and that the rationale for extra care home tests and how this would keep the public safer was not clear to him; the paper also noted that the Chief Medical Officer (Wales) had stated that attempts were still being made to understand the basis for the changes that had been made in England.

508. On 2 May 2020, the Health and Social Services Minister issued a Written Statement **AH2/362-INQ000182440**. In this statement, the Minister said that the scientific evidence did not support blanket testing and instead supported testing of symptomatic individuals combined with isolation pending test results. The Minister confirmed, in line with the advice of 30 April 2020, that there would be testing of all staff and residents in care homes experiencing an outbreak of the virus and testing of all staff and residents in larger care homes with more than 50 beds. As of 30 April 2020, there were 112 care homes with 50 or more beds in Wales.

509. The introduction of care home testing for residents and staff was operationally led by Public Health Wales using their labs to process tests. Local health boards provided the mechanisms to go into care homes to undertake the tests with residents and staff on site. Policy officials in the central testing team proactively contacted health boards and partners such as Care Forum Wales, to obtain information on how well the testing approach was being rolled out and to monitor health board and care home compliance with the policy, manually recording this data on spreadsheets. Dr Marion Lyons also played an important role in meeting with health boards and holding them to account, to ensure the testing was happening. At this time, there was no input directly from my directorate, but we were kept informed of progress.

510. Further to the Technical Advisory Group meeting on 1 May 2020, which had recommended that a consensus statement be produced, this was further discussed at its next meeting on 6 May 2020: **AH2/286-INQ000336505**. It was noted that the consensus was that, for new outbreaks, there was great value in testing the whole of the care home population. The Technical Advisory Group minutes also record that there were "multiple interpretations" of the ministerial statement of 2 May. My understanding is that this was a reference to the way that local health boards were implementing policy, which at that time varied according to local circumstances and operational need. In the coming days, this issue was addressed through the central testing team continuing to monitor and communicate with providers and health boards, as well as the establishment of a Care Home Testing Policy Group, which was in operation by August 2020. This group, which brought together key health board representatives, was chaired initially by officials from the central testing team. The purpose of the group was to oversee delivery of testing in care homes. The group continued to meet throughout the pandemic, monitoring data and considering the latest evidence on care home testing, making sure that there was compliance with policy and considering whether there any policy changes were required.

511. A consensus statement, approved by the Chief Medical Officer, was produced later that day on 6 May 2020 **AH2/285-INQ000336503**. The consensus statement confirmed, in line with the policy announcement on 2 May 2020, that there was evidence of value in mass testing of all residents and staff in a care home if a new symptomatic individual tested positive for the virus.

512. Also on 6 May 2020, Andrea Street and I received an email from the Director of Social Services of the Vale of Glamorgan Council, forwarding an exchange that he had with the local health board having requested testing for a care home that was in an established outbreak: **AH2/363-INQ000500177**. As the Local Health Board had explained, the new policy applied to new outbreaks of the virus after 2 May 2020 only, and did not require whole-home testing of care homes with an established outbreak where a resident or multiple residents had already tested positive for Covid-19 before the policy came into force. I am aware that this caused some confusion with the care home in question in this particular instance, and this policy was eventually changed so that care homes with ongoing outbreaks that had commenced before 2 May 2020 were also able to access tests (as confirmed in my and the Chief Medical Officer (Wales) letter to the sector on 13 May 2020: **AH2/364-INQ000368564**). Confusion of this nature was not uncommon in the early stages of the pandemic, when the benefits

and disadvantages of testing, and the circumstances in which testing was more useful and less useful as a tool, were not widely understood given its newness.

513. I am asked to explain, in relation to the communication from the Director of Social Services of the Vale of Glamorgan Council to which I have just referred, what the rationale was behind the decision not to include care homes within an established outbreak within the guidance on testing at this time. I understand that the thinking here, as reflected in the consensus statement referred to in paragraph 511 above, was that if there was already an outbreak within a home, the assumption should be that everyone is infectious and proper social distancing should be in place in any event. As such, care homes with known outbreaks focused on care for those who were ill and preventing further transmission into, out of, or within the home. As Covid-19 would already have been in these homes, with protections to prevent spread of the virus in place, limited testing capacity meant that available tests were prioritised to support sentinel testing at this time.

514. On 7 May 2020, I and the Chief Medical Officer (Wales) sent a letter to all local health boards and Directors of Social Services, announcing the move to testing of all staff and residents in care homes with an outbreak, with repeat testing as required, and testing also to be available for all staff and residents in care homes of more than 50 beds: **AH2/365-INQ000336510**. The letter also referred to the updated Public Health Wales 'Guidance to Prevent Covid-19 among care home residents', published that day 7 May 2020, which I have referred to in more detail in the section of this statement addressing hospital discharge decisions: **AH2/208-INQ000198367**.

515. For completeness, I note that the Public Health Wales guidance stated that there would be whole-home testing where there was a symptomatic case and where there had been no previous case in the previous 14 days. My understanding is that this reflected the fact that any testing within 14 days of an existing and confirmed outbreak would not be a good use of resources, as any subsequent cases within those 14 days would very likely be connected to the current outbreak.

Further expansion of care home testing – testing of unaffected care homes, 16 May 2020

516. On 12 May 2020, there was a SAGE meeting at which a "Care Homes Analysis" paper was discussed: **AH2/366-INQ000299676**. The notes of the meeting indicate that the co-chairs of the Technical Advisory Group attended this meeting on behalf of the Welsh Government. The Care Homes Analysis paper had been produced further to a request from the Chief Medical Officer (England) and Government Chief Scientific Adviser (England) for a scientific view on testing strategy to reduce transmission in care homes. The paper confirmed that the testing strategy that was then in place focused initially on care homes that had reported or suspected outbreaks, with larger homes prioritised. The conclusion reached with medium confidence was that, given the importance of trying to stop the spread of infection into homes, and the risk of asymptomatic infection and transmission, testing should be expanded to include homes that did not report cases, as well as those with suspected or confirmed cases. There was a strong scientific rationale to test all residents and all staff, irrespective of whether they were symptomatic or not, given the strong evidence of asymptomatic transmission in care homes. The paper stated that homes with positive returns should be re-tested on a weekly basis to monitor ongoing transmission, and homes with negative results should also be re-tested each week to check for importation of the virus or false negatives from previous testing rounds.

517. The SAGE paper was followed by a Technical Advisory Cell summary brief produced by the Chief Medical Officer (Wales)'s office the following day, on 13 May 2020: **AH2/367-INQ000253600**. The summary brief stated that the Technical Advisory Group agreed with the scientific advice outlined in the SAGE paper.

518. On 14 May 2020, advice was provided to Ministers based on the SAGE advice and further to discussion with Public Health Wales: **AH2/368-INQ000136783**. That advice, which was cleared by me, recommended the following approach:

a. Care homes reporting their first ever possible case of Covid-19 in a staff member or resident should be offered testing for the whole home;
b. Care homes with ongoing incidents in the previous 28 days should be offered testing of all residents who had not previously tested positive for Covid-19;
c. Care homes that had never reported a possible or confirmed case of Covid-19 should be tested – this being the key change, as under the previous strategy these homes would not have been tested.

519. As to repeat testing, the advice recommended this be done as appropriate for homes with positive results. For unaffected care homes, the advice was that the homes should be risk assessed and that repeat testing be undertaken as necessary (for example if there was a community hotspot). This was because the available capacity at that time did not support the level of tests that would be necessary to repeat test in all unaffected homes (which, the advice noted, would require in excess of 50,000 tests). It was considered that this proposal met the intention of the SAGE paper in relation to repeat testing. Repeat testing continued to be a theme that generated issues, as I explore further on in this statement.

520. The Ministerial Advice was followed by a Technical Advisory Group updated consensus statement on 15 May 2020 **AH2/369-INQ00066455**. The statement noted that:

a. There was strong evidence to support the testing of all residents and staff in a care home with a new outbreak of Covid-19 (and noted that the value of this testing would decrease over time from the point of the outbreak being identified);
b. Once the initial outbreak was over, there was evidence for the value of regular, selective screening of care homes, and surveillance testing of care home staff;
c. It would also be valuable to test in selected care homes that had not reported an outbreak.

521. Also on 15 May 2020, the Minister for Health and Social Services agreed the advice of 14 May 2020 referred to above: **AH2/370-INQ000336556**. The new testing programme was announced in the Ministerial statement that was published the following day, on 16 May 2020: **AH2/371-INQ000182446**. From 18 May 2020, key workers who showed symptoms could access a home testing kit through the UK online portal or a drive-through test by following the local arrangements.

522. On 17 May 2020, version 3.1 of the Public Health Wales guidance was published, which reflected the change: **AH2/372-INQ000395633**. On 20 May 2020, I and the Chief Medical Officer (Wales) wrote to care home providers regarding the practical arrangements for care homes accessing the testing, **AH2/373-INQ000500188**. Our letter referred providers to the 'Interim Care Home Testing Guidance' that the Welsh Government had published that day, and which advised providers how to request testing and how to provide daily reports to Public Health Wales and Care Inspectorate Wales: **AH2/374-INQ000500191**.

523. On 20 May 2020, the Older People's Commissioner wrote to the Minister for Health and Social Services, raising queries regarding how the new testing strategy would be implemented, including how often homes would be able to request tests and how soon the testing would be available: **AH2/375-INQ000184944**. The Deputy Minister for Health and Social Services responded on 1 June 2020: **AH2/376--INQ000338305**. The Deputy Minister confirmed that the new expansion of testing was already underway in care homes, relying on the testing capacity of the NHS in Wales and the Social Care Portal (an online test booking system for care homes) which had gone live on 1 June 2020. It was anticipated that all care homes would have been tested by 14 June 2020, and that from 15 June 2020 all care homes would be tested on a weekly basis for a four-week period (as I set out in more detail below).

Further expansion of care home testing – weekly testing of all care home staff, 15 June 2020

524. On 9 June 2020, the Minister for Health and Social Services published a Written Statement confirming that there would be weekly testing of all care home staff, for a four-week period, from 15 June 2020: **AH2/377-INQ000198394.**

525. On 10 July 2020, advice was provided to Ministers recommending the continuation of the weekly testing programme, until 10 August 2020: **AH2/378-INQ000336831**. It was agreed that the programme would continue on a weekly basis as before: I exhibit the relevant emails as **AH2/379-INQ000349704** and **AH2/380-INQ000349705**. I was in favour of the continuation of the weekly programme, as was Marion Lyons, as we did not consider that the risk had sufficiently subsided to reduce the frequency to fortnightly and we presented these views to Ministers. At this time there were on-going conversations around the benefits of testing domiciliary care workers, but the priority consideration at this time was care home staff, as outlined below.

526. Further advice was submitted to Ministers setting out the options for extending the care home staff testing programme on 5 August 2020: **AH2/381-INQ000136084.** It was subsequently confirmed that the programme would be extended until 4 October 2020, as announced on 6 August 2020 **AH2/382-INQ000368201** and noted in **AH2/383-INQ000136819.** At this stage, frequency of testing reduced from weekly to fortnightly for most of Wales apart from North Wales where community prevalence

rates remained high. A commitment to eight-weekly review points on testing patterns remained. The Welsh Government issued guidance in August 2020 confirming that all care home staff would be offered a fortnightly test for an eight-week period; with higher prevalence rates in some areas requiring an increase the frequency of the testing, I exhibit the guidance as **AH2/384--INQ000081369.**

527. The Welsh Government issued further guidance in November 2020 to help care home providers, local health boards, local authorities and others interpret and implement testing policy for care homes in Wales. Its main purpose was to clarify how to reduce the risk of transmission of Covid-19 in residential care home settings. I exhibit the guidance as **AH2/385-INQ000081585.**

Inclusion of domiciliary care workers in social care testing programme

528. The weekly care home staff testing programme outlined above did not initially apply to domiciliary care workers (domiciliary care workers including both workers providing care in people's homes and care workers based in supporting living settings). Consideration had been given to the inclusion of domiciliary care workers by the Social Services and Integration Directorate from an early stage, and officials prepared a written case in support of a move to routine asymptomatic testing of domiciliary care workers, which was initially submitted to the Welsh Government's Testing Cell on 10 July 2020: **AH2/386-INQ000500347**. Unfortunately, the paper was not considered by the Testing Cell at this time, but my officials, supported by Dr Marion Lyons and care provider representatives, continued to press the need to introduce testing for domiciliary care workers. The written case was further developed and refined, and re-submitted to the Testing Cell on 28 July 2020, with the intention that this was to be submitted for consideration by the Technical Advisory Group: **AH2/387-INQ000500346** is the updated written case dated 28 July 2020.

529. As set out in the written case, the Social Services and Integration Directorate was aware that there was real concern amongst domiciliary care workers that moving between multiple dwellings – as many domiciliary care workers do – could spread the virus, and that there was evidence of domiciliary care packages being refused by users due to anxiety over the risks of workers entering the home and potentially being a source of transmission. Domiciliary care workers encounter multiple numbers of highly vulnerable people, often as many as up to 12 in one day, and in some cases more. The written case noted the disparity between testing that was then available in

social care settings that was not available for domiciliary carers, without a clear rationale for why that was the case; and emphasised the need for public confidence in domiciliary care, particularly in light of lockdown measures easing and the potential for further pressures in the winter of 2020-2021, both of which were likely to increase demand for domiciliary care services.

530. However, the view was taken not to support routine, asymptomatic testing of domiciliary care workers, who were at that stage still considered lower risk than 'closed' settings such as care homes, and instead to test in geographical areas where there were higher prevalence rates of Covid-19. Given the limits on testing availability, and general concerns about the unintended consequences of false positive results when community prevalence was low, domiciliary workers were not considered a priority group, and the decision was they should continue to be excluded from the testing programme that applied to care home workers. There was, though, recognition that there was the potential for increased transmission between households as a result of home-based care provision, and for this reason it was decided that a sample of staff working in home-based social care services, such as domiciliary care staff and personal assistants, would be invited to take part in an antibody test study, aiming to assess what proportion of the workforce had been infected historically. I exhibit, for information, the letter that was sent out to domiciliary care workers from Social Care Wales on 14 September 2020, inviting their participation in the study: **AH2/388-INQ000500239**.

531. As recorded in the minutes of the Domiciliary Care Collaboration meeting that took place on 18 November 2020, **AH2/389-INQ000500292**, those antigen testing pilots were ongoing at that time in domiciliary care, and uptake from this had been low though it was known that domiciliary care workers were testing positive.

532. Following the introduction of Lateral Flow Testing, advice (MA/VG/3938/20) was submitted to Ministers on 20 November 2020, recommending that domiciliary care workers be included in the asymptomatic testing programme for frontline health workers and that agency staff, staff working in some larger supported living settings and visiting professionals to care homes also be included in the testing programme for care home staff: **AH2/390-INQ000144929**. This was agreed by the Minister and Deputy Minister for Health and Social Services on 23 November 2020.

533. As was recognised in the advice, many supported living settings provided accommodation and care for adults with learning disabilities, and the Public Health Wales report on Covid-19 related deaths amongst people with learning disabilities showed that *"comparison with deaths amongst all Welsh residents, suggests that the age-standardised rate of deaths involving COVID-19 is around 3x to 8x higher in this cohort than the population as a whole.'*

534. Based on this evidence, criteria were proposed and accepted to identify those supported living settings that, given their size and operational arrangements, should be treated as care homes and added to the full care homes testing programme, as against those settings that were smaller and 'lower risk' and could therefore be added to the domiciliary care testing programme.

535. Up until this stage, there had been limited capacity for PCR testing, which required laboratory processing. There was also the persistent challenge of managing the turnaround times for PCR testing, and reports of false positive results at times of low community prevalence, which impacted significantly on workforce availability. However, the introduction of Lateral Flow Testing, which could be made more widely available with quick results, meant that new priority groups for testing could be identified and supported, including domiciliary care workers.

536. Between November 2020 and January 2021 significant work was undertaken between the Welsh Government and the UK Government Department of Health and Social Care, working across local authorities, Care Inspectorate Wales, Care Forum Wales and Community Housing organisations to identify and categorise providers, develop detailed guidance on testing regimes for each type of setting and arrange for them to be added to the relevant testing programme, including setting individual providers up on the ordering portal so they could manage their own ordering and delivery after the initial 'push out' of tests via local authority delivery channels in December 2020.

LFT testing of visitors to care homes, 30 November 2020

537. The Ministerial Advice (MA/VG/3938/20) 20 November 2020 also recommended that the Welsh Government participate in the pilot being developed by the UK Government Department of Health and Social Care and Deloitte for the introduction of lateral flow testing of all visitors to care homes, initially from 30

November 2020 across 14 pilot care home sites, with the possibility that this would be extended to all care homes in Wales from 14 December 2020, if successful. This pilot was announced in a Written Statement published on 23 November 2020, and following this, the programme was extended to all care homes: **AH2/391-INQ000500294**. I exhibit, for information, the feedback from the pilot that was collated by the UK Government Department of Health and Social Care and shared with the Welsh Government on 9 December 2020: **AH2/392-INQ000500296, AH2/393-INQ000500295**. Ministers and I pushed to try and ensure that this capability was ready before Christmas, as families who had been separated for long periods of time due to lockdown restrictions and other control measures were desperate to be able to share some time together at this special time of year.

538. Rolling this out in time for Christmas was challenging and I am extremely proud of the collaborative effort made by all our stakeholders to make this happen for our care home residents and their families. To achieve this, we issued new guidance and training materials for staff at care homes to support effective and safe testing practice and established new national to local distribution channels, in which our local authorities played a key role as logistical coordinators and distributors. A new Local Authority Testing Leads group was established on 15 December 2020, which brought together social care testing leads from across Wales, to develop and operationalise the new distribution mechanisms for care providers. This group continued to meet throughout the remainder of the pandemic, providing an efficient interface between local authorities and the Welsh Government to support the effective operation of our testing policies.

539. Based on learning and feedback regarding the implementation of the testing of care home visitors, in January 2021 the Welsh Government introduced financial support to care homes to meet the additional cost burden of visitor testing and to facilitate the continued use of testing to support care home visiting: see MA/VG/0114/21, **AH2/394-INQ000145045**.

Twice-weekly Lateral Flow testing of frontline social care workers, 14 December 2020

540. On 4 December 2020, the Minister for Health and Social Services announced **AH2/395-INQ000420995** that the Welsh Government was introducing a programme of regular, twice-weekly asymptomatic testing of patient-facing health and social care

workers in hospitals and primary care and community care settings, including domiciliary care workers and professionals visiting care homes. This programme was implemented from 14 December 2020 alongside the roll out of testing for care home visitors and so made use of the same distribution channels through local authorities (and local health boards in relation to health care professionals).

541. Again, to illustrate our highly collaborative approach in Wales, the social care testing lead worked closely with the UK Department for Health and Social Care and Deloitte consultants throughout this implementation of lateral flow testing for social care staff and care home visitors, to ensure that Wales was able to benefit from the resources and expertise being developed in England. Specific guidance and training materials were adapted from the Deloitte materials developed in England to ensure they were accurate for the Welsh context.

542. Despite some initial concerns that care homes may feel the addition of twice-weekly lateral flow testing would be a burden, in most cases providers welcomed the additional safeguards that this testing regime afforded.

Testing for visiting professionals

543. Around this time, we also developed guidance for testing professionals visiting care homes which was set out in a letter sent to the sector by myself and the Chief Medical Officer (Wales) on 7 January 2021 **AH2/396-INQ000469078**. This was to ensure that testing was in place for anyone entering a care home from the outside who had the potential to bring infection with them. It was also intended to ensure community health staff could more easily access care homes to meet some of the health care needs of residents, noting that some care homes were being extremely protective and not allowing entry. The letter made it clear that care homes should immediately expect all health professionals to provide evidence of a negative test prior to crossing the threshold.

544. This testing for visiting professionals was welcomed by staff in organisations such as Care Inspectorate Wales. However, there were challenges raised by some local health boards and some health 'contractor' organisations such as GP surgeries, about introducing testing for community health staff. These challenges reflected the following concerns:

a) Health professionals were already well trained and well-practised in infection prevention and control, and they should be trusted to make a professional judgment as to the most appropriate infection prevention and control measures to take to ensure the safety of their patients and clients;
b) Requiring health professionals to factor in testing as part of their day-to-day routine was a significant drain on their time and capacity;
c) Concern that some local health boards had not made an adequate number of lateral flow tests available for primary care providers.

545. These issues were raised and discussed in several forums including the Social Care Testing and Infection and Prevention Control Group. Officials met with representatives of contractor organisations to discuss these matters and to clarify the policy and expectations. It was agreed that the general implementation of testing of primary care and community staff should proceed in principle as with other health board staff, but a range of further steps were agreed to support the policy, including ensuring better access to testing kits.

Ongoing roll out of testing

546. Once lateral flow testing capability became widely available, and people became conversant with the testing technology, there were increasing requests for testing to be made available for wider social care settings and services, and over time these were added to the testing programme.

547. In May 2021, a series of digital materials were distributed to the NHS in Wales and local authorities, as exhibited in **AH2/397-INQ000501613**, to promote the availability of lateral flow testing for:

i. Personal assistants (providing individual care and support to people in their own home).
ii. Unpaid carers.
iii. Community drivers (who were transporting vulnerable people to and from key services).
iv. People working in supported accommodation services.
v. People delivering other community support services such as care and repair (repairs to older people's homes).
vi. Agency staff delivering health and social care services.

548. There was also ongoing work to monitor and encourage compliance with the various testing regimes in place, including the requirement for health and social care staff to report their test results through the Test, Trace, Protect digital tool. This was a significant new introduction to manage, and it was an ongoing challenge to encourage exhausted social care staff to test three times a week and record their results via the digital tool.

Managing divergence from testing policy and creating local flexibility

549. I am asked to explain when the Health and Social Services Group came to learn of the divergence in approach by some local authorities which is referred to in the Ministerial Advice MA/VG/3302/20 dated 6 October 2020 **AH2/383-INQ000136819**, which noted that while the majority of care homes had continued the cycle of regular testing in line with policy, some local authorities and local health boards had chosen to increase the frequency of testing to weekly, without first consulting the Welsh Government. This was noted as having caused unpredictability in the system, with problems managing supply and demand. I was not personally involved in discussions about this issue or in the management of arrangements for testing availability to local authorities, but having consulted with policy officials, I understand that these variations would have occurred when local decisions were beginning to be taken to respond to changes in community prevalence rates, which were not always in line with the national policy position. For example, as local community prevalence rates dropped, local delivery partners and Incident Management Teams often reduced testing for a range of reasons including the opportunity to give staff and communities a break from testing, and to reduce potentially unnecessary outbreak management restrictions that would be triggered by any false positive results when local prevalence was low. These divergences of approach were however causing some concern and confusion for care homes and partner organisations.

550. It became evident from these reports that greater sophistication was needed on social care testing, to allow for greater flexibility to manage responses locally, tailored to local circumstances in terms of managing outbreaks and community prevalence. Testing policy officials, supported by Dr Marion Lyons, felt that while

some local flexibility might be useful, it needed to be considered and implemented within the parameters of national policy.

551. The case for allowing local flexibility was submitted to Ministers for consideration on 4 November 2020 as part of MA/VG/3500/20 along with proposed guidance for Incident Management Teams: **AH2/398-INQ000337225**. Accordingly, Ministers decided that the question of whether testing of asymptomatic care home staff should be weekly or fortnightly could be made at local level, informed by local intelligence and data on incidence and transmission in the local area, and giving advance notice to the Welsh Government before decisions were announced. The Minister recognised that local professionals were well-placed to make informed decisions using their knowledge of where outbreaks were happening, though it was expected that where community prevalence rates were high, asymptomatic staff testing would be undertaken on a weekly basis. This was confirmed in a Written Statement issued on 4 November 2020: **AH2/399-INQ000500350**.

552. Guidance to Incident Management Teams was developed by the Social Services and Integration Directorate and the Chief Medical Officer (Wales)'s office, which set clear parameters for local decision-making responsibilities, and expectations in relation to who should be involved in decision making, ensuring the social care sector was adequately represented, and also the data and intelligence that should be relied on to inform decisions. I exhibit a copy of the guidance at **AH2/400-INQ000337228.**

553. More generally, officials were able to stay informed of when and where local areas were diverging in their approach to testing, due to the communications network that was developed during the pandemic, which allowed officials to monitor how testing policy was being implemented across the country. This communications network included forums such as the National Residential Care Homes Oversight Group, the Health Boards Care Homes Testing Group, the Local Authority Testing Leads Group, and the Social Care Testing, Infection Prevention and Control Group. Through these groups, officials were able to collect and analyse data which highlighted where there may be gaps or deviation in policy implementation, and to take action where necessary. Where instances of non-compliance were suspected, further information was sought from the local bodies as to the reasons for the suspected divergence, and support provided to bring the local area back in line with national policy where necessary.

554. The Health Boards Care Homes Testing Group, which monitored health and social care testing delivery across Wales, periodically undertook reviews to establish the levels of testing being undertaken in care homes. In November 2020, it appeared that 36 care homes were not conducting testing, the assumption based upon the examination of test kit ordering patterns and test results. Health boards were asked to follow up with these homes to better understand the situation and to work with them to implement appropriate testing if it was found not to be in place. While monitoring was an ongoing activity, a further review took place in March and April 2021: **AH2/401-INQ000501606**.

555. Issues of divergence were discussed at length in the social care testing and infection prevention and control group on 18 January 2021, which I chaired: **AH2/402-INQ000501585, AH2/403-INQ000501586, AH2/404-INQ000501587** and **AH2/405-INQ000501589**. Members at the meeting agreed actions to:

a. Promote the importance of following Welsh Government policy which s based on the latest scientific evidence;
b. Communicate the importance of maintaining equal priority between testing and vaccination;
c. Communicate the scientific evidence to support the safe use of lateral flow tests, as there were reports of continuing concerns regarding the efficacy of tests leading to a reluctance to rely on them;
d. Remind local partners of governance and the need to record and formally communicate any divergence from national policy directly to the Welsh Government.

Re-testing or repeat testing

556. Re-testing positive results, initially with care homes but later with the wider social care sector, was a contended issue, and reflected low confidence in the accuracy of test results. As recorded in MA/VG/3302/20, the Welsh Government policy position was to re-test asymptomatic staff with positive results. The advice noted that there had been some decisions made locally to move away from that policy, on the basis that there was only a small percentage of false positive rates in period of high community prevalence. These decisions were causing concern among the care homes sector with serious implications of a 'false positive' result, relating to the potential for having to close the home for 28 days and removing their ability to admit

new residents. It was proposed that officials should undertake a 'deep dive' assessment of the data to consider this and other issues, to inform social care testing policy going into the autumn and winter of 2020.

557. Later, the policy changed so that a positive lateral flow test could be followed up with a PCR test, which was felt to be more accurate. Care providers were keen to ensure that re-testing continued to be available, as there had been many reports of asymptomatic false positive test results. Given the restrictions and consequences of positive test results (including staff isolation and care homes going into outbreak management mode, with all the associated restrictions for residents and staff), providers were keen to have assurance that tests results were accurate.

558. However, with the initial limited capacity for testing, re-testing was an additional draw on testing stocks and there was ongoing dialogue between the Welsh Government and Public Health Wales to ensure re-testing was being appropriately applied.

Welsh National Covid-19 Test Plan, March 2020

559. I am asked to summarise the Health and Social Services Group's involvement in the Welsh Government's National Covid-19 Test Plan, published in April 2020: **AH2/406-INQ000068666**. The Test Plan was of course not specific to social care and was developed by Health and Social Services Group officials with input from a range of stakeholders and experts, via a Covid-19 Test Plan Task & Finish Group which the Chief Scientific Adviser for Health chaired (Terms of Reference for this group are provided in exhibit **AH2/351-INQ000338227**). The group brought together different parts of the Welsh public sector, and other agencies, to rapidly build a system of testing and contact tracing largely from scratch and on an unprecedented scale. The costs associated with the Test Plan were met by the Health and Social Services Main Expenditure Group.

560. At the Minister for Health and Social Services's request, a public-facing version of the National Covid-19 Public Testing Plan was published on the 6 April 2020: **AH2/407-INQ000349273.**

561. I am asked in particular to explain the Health and Social Services Group's involvement in Public Health Wales's view that Wales would have capacity for 5,000 tests per day by the week commencing 6 April 2020, as had been set out in the Test Plan, and to explain when it became clear to the Group that this target was not going to be met. I was not personally involved in these projections or assessments, and nor were Social Services and Integration Directorate officials, but to assist the Inquiry I exhibit the rapid review of testing capacity that was commissioned by the Minister for Health and Social Services on 15 April 2020: **AH2/408-INQ000182403**. That review noted that we would not reach the target of 5,000 tests per day by 13 April 2020.

562. I am also asked to summarise the additional testing capacity from the UK arrangements, over and above the domestic target of 5,000 per day from the Public Health Wales laboratories.

563. I understand that this was a reference to the work that was carried out on a four-nations basis to increase testing capacity and accessibility. The UK Government worked in partnership with the other nations of the UK under the UK Testing Programme to increase laboratory capacity and set up additional testing sampling sites that included drive-through and walk-in centres across Wales. Mobile Testing Units were also deployed across Wales. These units provided flexible and rapid testing capabilities, crucial for reaching remote areas or places experiencing outbreaks. Under the programme, to aid accessibility, a system providing home testing kits was also established to allow individuals to test themselves at home.

564. The increase in laboratory capacity included establishing a lighthouse laboratory network, working alongside the NHS in Wales laboratory system, which was a significant part of the UK programme. These high-throughput laboratories processed samples from all over the UK, including Wales, and provided significant increases in overall testing capacity. Setting up the additional capacity at scale was not without challenge and during times of higher demand, turn-around times were impacted and occasional concerns were raised on the quality and reliability of test results. The establishment of a lighthouse laboratory in Wales provided a more robust service and also enabled samples to be transferred for genomic sequencing in NHS Wales laboratories.

565. The NHS in Wales laboratory system, mostly managed by Public Health Wales, was prioritised in the main to test patients, symptomatic health and care staff, and

outbreaks, including those in care homes. Sampling for the NHS in Wales laboratories was supported under the Wales Test, Trace and Protect programme and the laboratory results could provide a higher degree of information relating to the level of infectiousness a person had, rather than just a positive or negative result. Following the establishment of the UK Testing Programme, wider asymptomatic testing for care home staff and residents was processed by the lighthouse laboratories.

566. The UK Testing Programme also provided additional capacity for surge testing in response to outbreaks and the detection of new variants. Wales benefited from these intensified testing efforts to quickly identify and isolate cases to reduce transmission of the virus.

567. The possibility of additional capacity through the UK testing network was highly welcomed at the time, however challenges in relation to turn-around times for test results and the anecdotal reports of 'false positives' impacted confidence in the testing programme. The social care testing lead, supported by me and members of the central testing team, spent significant time responding to complaints about slow turn-around times, and working with stakeholders to listen, provide support, and help maintain confidence and commitment in the testing programme.

568. This included proactive work with the UK Government Department for Health and Social Care to maintain the focus on improving turn-around times in UK labs.

Social Care testing framework

569. Due to the growing complexity of testing for social care, it became evident that although there was a national testing plan in place, the specific details for testing in the social care sector needed to be laid out in a clear way to ensure understanding of what testing approaches should be applied where, when and for which specific social care services, staff and population groups. We made a case to develop a social care specific testing framework, and approval was granted by the Test, Trace, Protect Programme Board on 14 August 2020.

570. The social care testing framework was agreed by Ministers as part of MA/VG/3938/20 in November. A wide range of internal and external stakeholders were involved in the development of the social care testing framework which was led through the Social Care Testing and Infection Prevention and Control Group.

However, due to the pace of the pandemic and the move towards National Alert Levels, the social care testing framework was later subsumed within the Coronavirus Control Plan: Alert Levels in Wales for Social Care Services for Adult and Children. Following advice MA/VG/4402/20 submitted to Ministers on 22 December 2020, the plan for social care was published on 23 December 2020: **AH2/409-INQ000136834**, **AH2/249-INQ000081729**. This sector specific plan, the first of its kind in the UK, linked the social care testing, infection, prevention and control arrangements to the National Alert Levels document published by the First Minister on 15 December 2020. The document was well received by the social care sector who welcomed the clarity of the testing arrangements for all parts of the sector and the ability to foresee testing expectations should alert levels change.

Reflections on testing in adult social care

571. Over the pandemic, the capacity for testing improved with advancements in technologies which allowed for greater capacity, frequency and speed. This improvement was essential in supporting health and social care services and protecting vulnerable people. While there were, particularly in the early stages, some challenges with the speed at which we could obtain agreement to introduce testing arrangements for new cohorts (testing for asymptomatic domiciliary care workers being an example of this), when decisions were made, they were based on sound evidence, communicated swiftly and effectively and deployed quickly.

572. My reflection is that the strength of our response here in Wales, for social care but also more generally, was underpinned by three key principles:

i. A focus on keeping people safe. Safety of our citizens and in particular our most vulnerable populations was always the priority, not just for me but for my wider colleagues and Ministers. This underpinned all our decisions which is evident in our advice to Ministers. One example of this is how we made effective use of the evidence which indicated the increased risk of infection associated with people with learning disabilities. This evidence helped us to make the case that testing should be prioritised for this group and introduced into supported living settings to help keep this vulnerable group safe (as referred to in MA/VG/3938/20, exhibited above as: **AH2/390-INQ000144929**).

ii. Proactive collaboration and partnership working. From the start, the Welsh Government actively engaged with stakeholders to ensure its response was collaborative and informed by real experience and intelligence. Its collaboration with the UK Government Department of Health and Social Care and Deloitte colleagues was also an important aspect of its work, ensuring it could maximise the resources and expertise made available through the UK Government.

iii. A clear focus on using the evidence to inform decision making. Throughout the pandemic, advice to Ministers was informed by the evidence available and a clear rationale. Where there was little or no evidence, action was taken to carry out further investigation, for example by undertaking antigen studies for domiciliary care workers and working with Care Inspectorate Wales and housing associations to identify and categorise supported living settings across Wales in order to plan for and introduce testing capabilities for them.

573. During the pandemic, testing prioritisation was structured to focus on the most critical needs, according to the scientific evidence, clinical advice and professional judgment available to us at that time. A careful balance was needed to manage testing capacity limitations to protect hospital patients, residents and workers in care homes, wider NHS and care staff (including GPs and pharmacists for example) alongside targeting community outbreaks, protecting staff and children in education, and for broader public testing.

574. I believe the Welsh Government sought the right balance to implement targeted sector-specific testing frameworks (namely the Coronavirus Control Plan: Alert Levels in Wales for Social Care Services for Adult and Children) alongside wider community testing frameworks for the public, which allowed for more efficient management of outbreaks and targeted testing where it was most needed at that time.

575. Maintaining focus on the most vulnerable people in our communities and being prepared to respond to new variants or outbreaks remained critical for several reasons. During the pandemic, it became evident that certain populations, such as the elderly, people with pre-existing health conditions, and those in socioeconomically disadvantaged areas, were disproportionately affected. These groups faced higher rates of infection, severe illness, and mortality. By prioritising vulnerable populations in our public health strategies, including testing, we sought to ensure more equitable health outcomes and prevented the health and care system from becoming overwhelmed. Regular and targeted testing in these communities enabled early

detection and intervention, which was vital for controlling the spread of the virus and protecting those at highest risk.

Decisions relating to vaccinations and social care

576. I am asked by the Inquiry to comment upon aspects of the Welsh Government's vaccination programme as they relate to social care matters.

577. I was aware of the development and roll-out of the vaccination programme, though this responsibility sat outside my directorate. I recognised the importance of the Covid-19 vaccination programme as a critical element of our response to the pandemic. I was conscious that those in receipt of social care in Wales were particularly vulnerable to the virus, and moreover that some of the interventions necessary to protect them from the virus – such as restrictions on visiting – had other significant impacts. The vaccination programme was therefore a critical part of the Welsh Government's efforts to protect the vulnerable and prevent the spread of the virus within those settings, and to ultimately restore some sense of normality for care home residents.

578. I was aware of the Welsh Government's vaccination programme, and I have relied in this section on information provided in respect of Module 4 (vaccinations and therapeutics) from several members of the civil service, both past and present.

Covid-19 Vaccination Board for Wales

579. I am aware that a Covid-19 Vaccination Board for Wales was established in 2020, the purpose of which was to assure system readiness for the deployment of Covid-19 vaccines to the population of Wales, by providing leadership and oversight to support the planning, coordination, and management of the vaccine rollout across Wales. I understand the first full meeting of the Board was held on 18 June 2020. I did not attend these meetings, but a member of my team represented the Social Services and Integration Directorate. The Board considered social care workforce matters as I set out below.

580. There were also several sub-groups to the Board, each with its own specific terms of reference and functions to fulfil. These included a Social Care Home and

Domiciliary Care sub-group, which was chaired by a member of my directorate. The purpose of this sub-group was:

i. To outline actions and options to facilitate and support maximising flu vaccine and Covid-19 vaccine amongst social care workers, vulnerable clients and carers.
ii. To understand the challenges of delivering the flu and Covid-19 vaccination programmes in social care settings.
iii. To support maximum uptake of vaccines in these target groups.
iv. To work closely with the communications sub-group (another sub-group of the Board) to understand what communication activity was necessary to help promote take up of vaccine and dispel myths around the programme for the social care sector.

581. These sub-groups and the work they undertook were the subject of regular reporting to the Covid-19 Vaccination Board, identifying actions, risks and issues and support needed. They highlighted where, for example, national guidance was required, or additional training, extra funding needs and additional human resources. All sub-groups were required to have in their mind a 'Once for Wales' approach for the delivery of their objectives, to ensure efficiency and completeness, as I describe for social care below. I exhibit as an example the Once for Wales reporting slide set for the Board meeting on 7 January 2021, at **AH2/410-INQ000410071**.

582. For completeness, the other subgroups reporting to the Board were:

i. Programme Workforce
ii. Training and Healthcare Professional Information
iii. Vaccine Logistics
iv. Data, Epidemiology, and Digital
v. Primary Care
vi. Communications and Media
vii. PPE/consumables

583. In undertaking its work, the Social Care Home and Domiciliary Care sub-group was able to build on structures already in place to promote take-up of the influenza vaccine amongst social care staff. It brought together stakeholders from across social care – including the regulators, Care Inspectorate Wales, Social Care Wales, Care Forum Wales, local authorities, NHS Wales, and Public Health Wales – to discuss and agree the best ways to encourage the workforce to take up the vaccine.

584. At its meeting on 15 September 2020, the Covid-19 Vaccination Board considered a paper prepared by a member of my team about maximising both flu and Covid-19 vaccine update amongst social care workers. This was critical both to protect the workforce (and residents) from the virus and to ensure those in receipt of social care were receiving the care and support they required, as staff absences due to illness put additional pressure on an already stretched workforce.

585. The paper outlined the work of the Social Care Home and Domiciliary Care Worker sub-group in highlighting potential barriers to take-up amongst the social care workforce. The issues raised included the need for a clear timetable for vaccination of the workforce, clarity on eligibility, and improved communications to the workforce about the importance of vaccine take up. The paper also outlined the next steps which would be taken, in relation to the communications plan, the engagement of local authority Directors of Social Services, and work with Social Care Wales on the definition of a domiciliary care worker. I exhibit the paper at **AH2/411-INQ000492971**[26], and the minutes of the meeting at **AH2/412-INQ000500244**.

586. On 15 October 2020, the Covid-19 Vaccination Board received a 'Once for Wales' presentation on the social care workforce, from a member of my team. The presentation described the size and make-up of the social care workforce in Wales, and highlighted several challenges which would need to be considered as part of the vaccination rollout:

i. The 30% annual staff turnover rate
ii. Challenges in defining social care role given the variations across the sector
iii. The fact that not all workers in the sector needed to be registered with Social Care Wales

587. The presentation noted that health boards, as the main delivery partner, had worked with the local authorities within their areas, either as individual authorities or via Regional Partnership Boards, to prepare for the vaccination programme. Local authorities were working on logistical issues and were also supporting the dissemination of messages to the adult social care sector. I had asked all Directors of Social Services to provide an update on how they were engaged with health board planning; at that point the majority confirmed that they had been engaged with aspects

[26] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000500253]*

of this work, but several responses were outstanding. The Covid-19 Vaccination Board presentation further noted that challenges relating to accurate workforce data and the identification of eligible front-line staff remained. I exhibit the presentation at **AH2/413-INQ000429013**, and the minutes of the meeting at **AH2/414-INQ000429007**. Relatedly, I also exhibit a letter that I sent to all Regional Partnership Boards on 9 October 2020, asking for assurance that the Boards' Winter Protection Plans covered the vaccination programme and would ensure that local authority and health board partners were jointly and effectively planning to immunise the social care workforce: **AH2/415-INQ000500342**.

Joint Committee on Vaccination and Immunisation

588. The Joint Committee on Vaccination and Immunisation (JCVI) is an independent advisory committee with statutory functions in both England and Wales. Its status in Wales is as an advisory body and it provided advice throughout the pandemic, which was considered and accepted by Ministers as part of their decision-making in relation to vaccination.

589. On 25 September 2020 the Joint Committee on Vaccination and Immunisation published an update to its advice to facilitate planning for the deployment of any safe and effective vaccine(s) as soon as they were authorised for use in the UK. The advice is exhibited as **AH2/416-INQ000417454**[27]**.** The Committee agreed that a simple age-based approach would result in faster delivery and better uptake in those at highest risk and set out a provisional ranking of prioritisation. The first two priority groups were:

(a) Older adults' resident in a care home and care home workers;

(b) All those 80 years of age and over, and health and social care workers;

590. I was aware of the Committee's advice that residents in care homes and care home workers had been identified as part of the first priority groups for vaccination.

591. One of the early challenges faced by the vaccination programme as it related to social care was the ultra-low temperature storage requirements of the Pfizer vaccine. I understand that advice (MA/VG/4049/20, exhibited at **AH2/417-INQ000410016, AH2/418-INQ000361639**) was submitted to the Minister for Health

[27] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000500348]*

and Social Servies on 24 November 2020 which explained that the vaccine required ultra-low temperature storage at below minus 70 degrees Celsius, but the manufacturer could not guarantee vaccine efficacy if transported once thawing had commenced. This effectively precluded mobile team administration models for care home residents, prioritised in the Joint Committee on Vaccination and Immunisation advice, until further data from Pfizer testing was forthcoming, which was after the commencement of deployment.

592. The Minister therefore agreed a recommendation not to transport nor use the Pfizer vaccine in care homes for the first four weeks of delivery. That would enable officials and healthcare workers to learn more about the characteristics of the vaccine and provide an opportunity to train the workforce. The email is exhibited at **AH2/419-INQ000410017**. In that email the Minister also requested a note updating on readiness for vaccine deployment more generally, which could be forwarded to Cabinet colleagues, and which I exhibit for completeness at **AH2/420-INQ000410020**.

593. Wales received a supply of a Covid-19 vaccine during the first week of December 2020. The following week, on 8 December 2020, the first vaccine in Wales was administered. This came just days after the Medicines and Healthcare products Regulatory Agency approved the first Pfizer BioNTech vaccine. In announcing the roll-out of the programme in Wales, the Welsh Government confirmed that priority would be given to those aged 80 and over, care home staff and residents as soon as possible, and those working on the frontline within health and social care. The Written Statement is exhibited at **AH2/421-INQ000321010**.

594. I understand that on 24 December 2020 the Minister for Health and Social Services received a further update, which is exhibited at **AH2/422-INQ000410049**, which included the latest intelligence and activity on the Oxford/Astra Zeneca vaccine, on which an announcement about approval was expected on 29 December 2020. I refer to this because of its significance from a social care perspective, in that the Oxford/Astra Zeneca vaccine did not have the cold storage requirements of the Pfizer vaccine. I understand that Astra Zeneca announced on 30 December 2020 that its vaccine had been authorised.

595. On 30 December 2020 the Joint Committee on Vaccination and Immunisation withdrew its interim advice of 25 September 2020 and replaced it with updated advice to facilitate the development of policy on Covid-19 vaccination in the UK, which I

exhibit as **AH2/423-INQ000408135**[28]**.** The Committee advised that the first priority should be preventing mortality and protecting health and social care staff and systems. On this basis, the slightly revised vaccine priority groups were:

i. Residents in care homes for older adults and their carers;
ii. All those 80 years of age and over, and frontline health and social care workers;
iii. All those 75 years of age and over;
iv. All those 70 years of age and over and clinically extremely vulnerable individuals;
v. All those 65 years of age and over;
vi. All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease mortality;
vii. All those 60 years of age and over;
viii. All those 55 years of age and over;
ix. All those 50 years of age and over.

596. On 4 January 2021 the Minister for Health and Social Services issued a Written Statement on the vaccine deployment in Wales, which I exhibit as **AH2/424-INQ000388300**. The statement noted that because the Astra-Zeneca vaccine did not have the storage issues associated with the Pfizer BioNTech vaccine it would allow more flexibility and mobile deployment models. That meant every care home within Wales was within reach and that this priority group, together with those of the age of 80, was to be targeted by the NHS over the coming weeks.

597. On 11 January 2021 the Minister for Health and Social Services confirmed the publication of the national Covid-19 vaccination strategy, which I exhibit as **AH2/425-INQ000386253**. The strategy set out three key milestones, the first of which was that by mid-February all care home residents and staff, front line health and social care staff, everyone over 70 and everyone who was clinically extremely vulnerable would have been offered vaccination. The strategy was underpinned by a 'nobody left behind' principle, built on the premise that everyone should have fair access and fair opportunity to take up the offer of a Covid-19 vaccination. I was aware of the targets for vaccination of those living or working in adult social care settings.

598. On 27 January 2021 the Minister for Health and Social Services agreed to define, for the purpose of vaccination prioritisation, the meaning of "frontline social

[28] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry.[INQ000388283]

care workers". I exhibit the Ministerial Advice, into which I was copied, at **AH2/426-INQ0000145056.** The Joint Committee on Vaccination and Immunisation's advice of 30 December 2020 had provided some guidance on this, but the view was that further clarification was required of who was included within the "frontline social care workers" group. A commitment had already been made to include within the priority groups referred to above, all education staff who provided intimate personal care for children and young people with complex needs. It was further agreed that foster carers would be similarly categorised as frontline workers on the same basis, including those caring for children and young persons with complex medical needs being prioritised.

599. The following day, on 28 January 2021, Gillian Richardson (Deputy Chief Medical Officer (Wales)) and I wrote to the Responsible Individuals for adult care homes and domiciliary support services for supported living. In our letter, exhibited at **AH2/427-INQ000500234**, we reinforced the importance of determining the mental capacity of individuals to make a decision about receiving the vaccination, and enclosed up to date guidance on this matter. Our letter also noted that some staff and residents might have been reluctant to receive the vaccination and stressed that whilst individuals had the right to decline the vaccine, their hesitation might have been the result of a lack of information. We therefore encouraged staff and the public to refer to the information available from Public Health Wales. We stressed our keenness that all staff and residents should receive the vaccination.

600. On 2 February 2021, I and the Chief Medical Officer (Wales) wrote to Chief Executives of health boards/trusts, and local authority Directors of Social Services, about the definition of frontline social care workers. We noted that we were aware of some differing interpretations of the Joint Committee on Vaccination and Immunisation's 30 December advice as to which social care workers fell within the scope of the definition for vaccine prioritisation purposes. Guidance on the definition of frontline social care workers for the purposes of vaccine prioritisation had therefore been produced and was attached to our letter. The overarching position set out in the guidance was that to be prioritised for the vaccine, social care workers needed to be dealing directly with vulnerable people, delivering intimate personal care on a regular basis to those who were defined by the Committee as clinically vulnerable to Covid-19. The letter is exhibited at **AH2/428-INQ000183715**[29]**.** An amended and updated

[29] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000492804]*

version of our letter was issued on 4 February 2021, which is exhibited at **AH2/429-INQ000299972**.

601. Therefore, the frontline social care worker guidance was published on 11 February 2021 to provide a clear definition of what constituted frontline staff for the purposes of the vaccination rollout, and I exhibit it at **AH2/430-INQ000081839.** Although this was clinical guidance, the officials who represented Social Services and Integration Directorate on the Covid Vaccination Board supported its production. The guidance cited the Green Book[30] description of frontline social care staff as those:

i. Working in long-stay residential and nursing care homes or other long-stay care facilities where rapid spread was likely to follow introduction of infection and cause high morbidity and mortality,
ii. Social care staff directly involved in the care of their patients or clients,
iii. Others involved directly in delivering social care such that they and vulnerable patients/ clients were at increased risk of exposure.

602. The purpose of the guidance was also to ensure the vaccination of those social care workers that would have the greatest positive impact took place as quickly as possible. Eligibility was to be based upon the vulnerability of the person in receipt of care or support, and the nature of the care and support provided.

603. The following day (12 February 2021) the Minister for Health and Social Services issued a Written Statement in which he confirmed that the first milestone of offering everyone in the first four priority groups vaccination by mid-February had been achieved as planned. The NHS in Wales had confirmed everyone in the first four groups had been contacted to be offered a vaccination appointment; this included residents in care homes for older adults and their carers (priority group 1), and all those 80 years of age and over, and frontline health and social care workers (priority group 2). The statement (exhibited at **AH2/431-INQ000500351**) confirmed that at that point, the NHS in Wales had vaccinated more than

i. 48,000 residents of older people's care homes and their staff carers;
ii. 161,000 over-80s;
iii. 118,000 NHS frontline workers; and
iv. 260,000 over-70s.

[30] Published by the UK Health Security Agency, the Green Book has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK.

604. I understand that Wales was the first of the four UK nations to reach this key milestone.

605. The Joint Committee on Vaccination and Immunisation advice on prioritisation of the vaccine rollout referred to above included unpaid carers in priority group 6. On 16 February 2021, the Minister for Health and Social Services received advice (MA/VG/0709/21, exhibited at **AH2/432-INQ000116605**) produced by Social Services and Integration Directorate officials, which set out proposals relating to the vaccination of unpaid carers. It noted that the previous week, the Joint Committee on Vaccination and Immunisation had revised its definition of unpaid carers eligible for prioritised vaccination from the definition that had originally been included in the Joint Committee's advice of 30 December 2020. The Ministerial Advice recommended that the Welsh Government should issue guidance which would include an eligibility criterion based on the unpaid carer undertaking personal care or care in close proximity to the cared for person, who was in a high-risk group. The advice also recommended that Ministers agree that more than one person could be vaccinated due to their joint-caring role as the 'primary carer', as recommended by the Joint Committee.

606. The Ministerial Advice noted that there were challenges in identifying eligible unpaid carers due to the lack of definitive data and the fact that many did not self-identify. The Welsh Government worked with care organisations and health board vaccine teams to develop an online form for people who were not already registered as an unpaid carer (with their GP or local authority) to be identified on the Welsh Immunisation System, exhibit **AH2/433-INQ000492818** refers.

607. The recommendations were agreed, and I exhibit the guidance, which was produced by Social Services and Integration Directorate officials and published on 24 February, at **AH2/434-INQ000492866**.

608. On 23 February 2021 advice was given to the Minister on a proportionate and more inclusive approach to vaccine prioritisation for those with severe mental illness or learning disability, to avoid missing those vulnerable persons who should be vaccinated. This advice is exhibited as **AH2/435-INQ111145094**. The advice noted that evidence from studies by both the Office for National Statistics and Public Health England showed that individuals with a learning disability were at a greater risk of Covid-19 mortality than those with no learning disability. The Welsh Ministers decided to adopt an inclusive approach by adopting the guidance, which was closely based on

the Joint Committee on Vaccination and Immunisation advice and criteria but would result in the inclusion of some individuals outside the severe/profound learning disability definition and coded within the serious mental illness groups, which the Committee had adopted.

Encouraging and promoting vaccine take-up

609. In the early stages of the vaccine being rolled out, Social Services and Integration Directorate officials met with social care sector representatives to understand more about apparent vaccine hesitancy that was being reported amongst social care staff. The reasons for this hesitancy were various and included, for example, concerns about potential impact of the vaccine on fertility, concerns about bad reactions to the vaccine, and concerns about potential interaction of the vaccine with pre-existing health conditions such as diabetes. I exhibit by way of example an internal email thread between officials in my Directorate discussing this feedback and possible ways of addressing the concerns: **AH2/436-INQ000500321**, and an email reporting the Directorate's positive engagement with the GMB Union and with Unison: **AH2/437-INQ000500327**. The Directorate was also involved in work to ensure that the vaccine was made accessible to agency workers in social care: **AH2/438-INQ000500322**.

610. I am aware that as part of its vaccination programme, the Welsh Government established a Vaccination Equity Committee. The Vaccination Equality Committee brought together representatives from third sector organisations, as well as experts from Public Health Wales and the NHS, to understand the barriers to Covid-19 vaccinations for marginalised groups and to try to remove those barriers. I understand it met for the first time on 21 April 2021.

611. Membership of the group included the Office of the Older People's Commissioner for Wales, Disability Wales, Mencap, Learning Disability Wales, All Wales Forum of Parents and Carers, RNID (the national charity which supports people who are deaf, have hearing loss or tinnitus), the Royal National Institute of Blind People (RNIB), the Bevan Commission, Public Health Wales, Community Housing Cymru, Citizens Advice Cymru, Cymorth Cymru, and the British Red Cross. The Vaccination Equity Committee Terms of Reference and membership are provided in exhibit **AH2/439-INQ000182550**.

612. I also understand that a Covid-19 Vaccination Programme Development Group was established to deal with day-to-day decision-making responsibilities to ensure the successful delivery of the Vaccination Programme. The group was chaired by the Senior Responsible Owner for the Welsh Government's Covid-19 Vaccination Programme, and its responsibilities included managing Covid-19 Programme communications.

613. A member of the Welsh Government Health and Social Services Group communications team sat on the Wales Covid-19 Vaccination Board (and its successors) from August 2020, and worked alongside the communications team in Public Health Wales, forming a Communications subgroup of the board and developing and delivering a communications and engagement plan. They were also responsible for drafting the Frequently Asked Questions and accompanying text for the Welsh Government's website; updating and sharing the information with partners and stakeholders. A member of my team sat on this group and ensured that specific issues or concerns raised by the social care sector were included and answered in these Frequently Asked Questions updates.

614. Of particular interest from a social care workforce perspective, was the work undertaken by colleagues elsewhere in the Health and Social Services Group to promote vaccine take-up amongst Black, Asian and Minority Ethnic communities. The Social Care Wales workforce report of March 2021 exhibited at **AH2/440-INQ000498725** found that workers from diverse backgrounds were represented at a higher proportion in the social care workforce than in the general population in Wales (although I note that the March 2022 workforce report found that the ethnicity of the social care workforce broadly mirrored that of the Welsh population); 2022 report exhibited at **AH2/441-INQ000498726**).

615. A communications strategy for Wales was written and shared with clinicians in January 2021. The strategy is exhibited as **AH2/442-INQ000388308.**

616. The Welsh Government engaged a contractor specialising in communications with multi-cultural groups to supplement the mass reach advertising to ensure that messages were accessible to Black, Asian and Minority Ethnic communities. Between April and September 2021, the reach of paid media advertising aimed at reinforcing relevant behaviours to this audience exceeded expectations. Including digital advertising, in this phase 97.17% of the audience was reached between these dates.

617. Between November 2020 and March 2021, the Welsh Government, working with its contractor, worked with 60 community and faith partners from across Wales. It also engaged with more than 120 representatives from Minority Ethnic community and faith organisations at the Vaccines Question and Answer – an online panel discussion with trusted voices and experts answering people's questions about the vaccines. The contractor found influential community leaders and members ('trusted voices') to deliver messaging to groups who were not otherwise engaged with Welsh Government communications.

618. The Welsh Government also published on 23 March 2021 a Vaccination Equity Strategy. Its purpose was to provide advice to the Programme Board on how to ensure all people in Wales who were eligible for Covid-19 vaccination had fair access and fair opportunity to receive their vaccination, by addressing barriers that disproportionately affected under-served population groups. The Vaccination Equity Strategy (which I exhibit at **AH2/443-INQ000182538**) sat underneath the National Vaccination Strategy, which set the 'nobody left behind' principle. An updated version of the Strategy was published on 23 March 2021, by which time than 1.2 million people in Wales had received their first dose of the vaccine, and more than 350,000 people were fully vaccinated, having received both doses of the vaccine. From a social care perspective, the strategy noted that over 95% of older person care home residents had received their first dose and over half had received their full course of the vaccine. The strategy also provided an update on work to maintain high take-up and ensure equality and equity of access. The strategy is exhibited at **AH2/444-INQ000492873.**

Vaccine take-up, and mandatory vaccination of care home workers

619. I was aware of the monitoring of vaccine take-up amongst the social care workforce. I understand that this data is collected through the Welsh Immunisation System, which was and continues to be the digital platform for Covid-19 vaccination which records (amongst other things) when a patient has received a vaccine. This record provides the data by which the NHS in Wales conducts surveillance, informing surveillance reports prepared and published by Public Health Wales.

620. I understand that these surveillance reports were produced on both a daily and a weekly basis from an early point in the Covid-19 vaccine programme. The daily

reports updated on how many vaccines had been administered for each of the priority groups, whilst the weekly reports provided deeper, quantitative analysis, such as take up by age and socio-economic indicators, ethnic minority group and deprivation quintile. Public Health Wales published these surveillance reports on its website. The reports included details of take-up amongst care home workers; I exhibit an example, dated 16 February 2021, at **AH2/445-INQ000410092**.

621. The issue of vaccination as a condition of deployment for health and social care staff in Wales was considered on several occasions by Welsh Ministers but it was decided that compulsory vaccination was not necessary, largely because of the high voluntary uptake of the vaccine by those working in the sector in Wales. As explained above, the vaccination of those working in health and social care had been prioritised in accordance with the Joint Committee on Vaccination and Immunisation's advice. The same prioritisation was adopted in relation to the booster programme, as set out in our national vaccine strategies. The Welsh Government's preferred approach was to work with those in the health and social care sectors to address any reluctance to the uptake of the vaccine, rather than impose compulsory vaccination, to ensure vaccination was accessible to the workforce, and to monitor vaccination rates.

622. I understand that in March 2021, the Social Care Working Group of SAGE had advised in a Consensus Statement that a vaccination rate of 80% in staff and 90% in residents provided the minimum level of protection against further outbreaks in care homes for older people. As of 16 June 2021, first and second dose vaccination rates for residents and care home workers in Wales greatly exceeded the minimum threshold recommended by SAGE. I exhibit at **AH2/446-INQ000485794** an email into which I was copied, which confirmed that, as at that date, 92.3% of care home workers had received a first dose of the vaccine and 85.7% had received their second dose. Vaccination rates amongst care home workers were higher than in England.

623. I recollect that in June 2021, the UK Government undertook a consultation exercise on mandating vaccination. I understand that a Cabinet ministerial call took place on 24 June 2021, during which the mandatory vaccinations for care home staff was discussed. A briefing paper on mandatory vaccination had been circulated in advance of that meeting, which I attach as **AH2/447-INQ000485797**. The views of stakeholders were recorded in the briefing paper, including Care Forum Wales, Social Care Wales and the Royal College of Nursing. I received an update on the outcome of the Ministerial call, which I exhibit at **AH2/448-INQ000485799**.

624. At that meeting on 24 June 2021, the First Minister had also invited consideration on the publication of care home data on staff vaccination. A paper was produced by members of my team and submitted to the First Minister; I exhibit the paper at **AH2/449-INQ000485939**. The paper set out a range of practical considerations and recommended that given the generally high level of uptake of vaccination among staff and the approach of promotion and encouragement of vaccination, rather than compulsion, the requirement to publish details of staff vaccination rates at the level of individual care home services at this time might not have been considered proportionate or in line with this approach.

625. In response, the First Minister indicated he did not wish to pursue mandatory publication but instead considered means for providers to make this information available voluntarily. An updated note was submitted by members of my team on 7 July 2021, exhibited at **AH2/450–INQ000495979** and 28 September 2021, which I refer to below.

626. On 29 June 2021 the Minister for Health and Social Services issued a statement noting that the uptake of the vaccine in care home workers had been high and that the Welsh Government was working with the NHS and the care sector to continue to monitor the situation. The statement confirmed that there were no plans to change the law to make vaccinations compulsory in Wales at that point. I exhibit the Minister's press release as **AH2/451-INQ000490080.**

627. On 9 July 2021, the Welsh Government published Covid-19 vaccinations; guidance for employers, which I exhibit as **AH2/452-INQ000082149.** The guidance highlighted that the UK Government had confirmed that vaccinations for care home staff would become mandatory in England. The guidance noted that vaccination rates within care homes in Wales were above levels advised by SAGE as advisory (80%) at that time. The guidance encouraged workers in care homes to take up the vaccination and noted the situation would be kept under review.

628. On 13 September 2021 Cabinet considered a set of papers relating to the 21-day review of the coronavirus regulations, which was due on 16 September. One of these papers (exhibited at **AH2/453-INQ000057876**) provided updates on responses to rising cases, noting that 91% of staff in older adult care homes in Wales had been double vaccinated.

629. On 8 November 2021 the Minister for Health and Social Services received a further briefing on the mandatory vaccination for NHS and social care workers. The paper again highlighted the high uptake of vaccination amongst health and social care workers, as well as the legal, ethical and workforce issues associated with making vaccination compulsory. The briefing is exhibited at **AH2/454-INQ000485872**. The position remained that compulsory vaccination for health and social care staff would not be introduced in Wales.

Reflections on the vaccination programme

630. I was always clear about the critical importance of the vaccination programme in combatting the virus and in particular its impact on those in receipt of social care support, who were amongst the groups most vulnerable to the virus, and in protecting the social care workforce. I believe that the roll out of the vaccination programme in Wales is one of the successes of the pandemic, including in relation to social care.

Easements under the Coronavirus Act 2020

631. I have been invited to provide a summary of the easements made under the Coronavirus Act 2020 with regards to the duties and obligations owned by local authorities under the Social Services and Well-being (Wales) Act 2014.

632. Through my officials, I am aware that on 8 October 2019 the Minister for Health and Social Services agreed the drafting of Welsh provisions to be included in the draft Pandemic Influenza (Emergency) Bill which was then almost complete. I exhibit the Ministerial Advice as **AH2/455-INQ000210787**.

633. The Ministerial Advice noted that pandemic influenza was a top risk on the National Risk Register and there was a UK four nations approach to pandemic preparedness, which was set out in the UK Influenza Pandemic Preparedness Strategy and agreed by Health Ministers of all four nations. The UK Department of Health and Social Care was the lead Government department with responsibility for responding to this risk and initially intended to present a draft Bill to Parliament at the end of September.

634. The advice set out that the draft Bill was always intended to be temporary and to come into force only in an emergency. The Bill contained measures designed to

either amend existing legislative provisions or introduce new statutory powers which were designed to mitigate these impacts. The purpose of the clauses was to streamline systems and increase capacity in the health care system and to mitigate infection. It followed a meeting of the National Security Council (Threats, Hazards, Resilience and Contingencies) committee in February 2017, at which the Prime Minister agreed a cross-Government work programme to further enhance pandemic influenza preparedness, work which was jointly led by the UK Department of Health and Social Care and the Civil Contingencies Secretariat in the Cabinet Office.

635. This resulted in a Review of the UK Pandemic Influenza Preparedness and the preparation of a freestanding draft Pandemic Influenza Bill, which could be fast tracked through Parliament. Welsh Government officials were involved in the UK Review and were represented on the UK Pandemic Influenza Readiness Board, jointly chaired by senior officials from the Cabinet Office and the Department of Health and Social Care.

636. Following the summer of 2017, the Ministerial Advice describes active engagement across the four nations to work collaboratively to prepare a single UK wide draft Bill. In Wales, discussions on the draft Bill's broad content were undertaken with members of the Welsh Government Pandemic Flu Group (which included the Chairs of the four Local Resilience Forum Pandemic Flu Groups in Wales) and the Wales NHS Emergency Planning Advisors Group (which includes contingency representatives of all 10 NHS organisations in Wales). Due to the sensitivity of the draft Bill no formal public consultation was undertaken.

637. The process for wider engagement had not yet been agreed, however the advice described that a four-nation stakeholder engagement and handling plan had been developed and agreed to ensure engagement took place in a coordinated manner across the four nations. The plan outlined how the UK Government, in conjunction with Devolved Governments, and led by the Department of Health and Social Care would conduct engagement in the period leading up to introduction of the Bill through to it being passed into law. The plan was complemented by the UK Pandemic Influenza Public Health Communications Strategy for the UK and the UK Influenza Pandemic Preparedness Strategy.

638. A first draft of the Bill was initially produced in December 2018 and officials in Devolved Governments were asked to consider their respective devolved areas and

to confirm if additional clauses were necessary to ensure the Bill would be effective across all four nations. From that time until the Covid-19 pandemic, Social Services and Integration Directorate officials were engaging with the UK Government to ensure that the provisions within the draft Bill would apply in relation to Wales.

639. Additionally, there were ongoing discussions between policy and legal officials across the Welsh Government and with other Devolved Governments to adapt the then draft Pandemic Influenza (Emergency) Bill to ensure it was also relevant to Coronavirus. This work involved combining the original draft clauses for the draft Pandemic Influenza (Emergency) Bill with additional provisions for Coronavirus to enable Ministers and, where appropriate local authorities, to respond flexibly during a pandemic.

640. On 20 February 2020 the draft Pandemic Influenza (Emergency) Bill was renamed the Coronavirus Bill. It was a UK Parliament Bill.

641. The effect of the Coronavirus Act 2020 in Wales was, among others, to make provision for easements, and modifications to the Social Services and Well-being (Wales) Act 2014 (the 2014 Act) in Part 2 of Schedule 12. The detail included as follows:

a. Local authorities did not have to comply with their duties in sections 19, 20, 24, 25 of the 2014 Act (and in regulations made under section 30 in relation to those duties) to carry out assessments of needs. It also provided that a local authority did not have to comply with the duty under section 32 of the 2014 Act to make a decision as to whether a person had eligible needs (i.e. needs which the local authority might have a duty to meet).
b. Local authorities did not have to carry out a financial assessment in accordance with section 63 of the 2014 Act in respect of a person whose needs it was going to meet but provided that a local authority which did not do so might not make a charge for meeting those needs.
c. Local authorities did not have to comply with the duty (under section 54 of the 2014 Act) to prepare care and support plans before deciding how to meet needs; the requirement for local authorities to review care and support plans was similarly removed.
d. Local authorities which would otherwise have had a duty to meet an adult's eligible needs only had a duty to meet needs in order to protect the adult from abuse or

neglect or a risk of abuse or neglect. This also applied in respect of the duty to meet an adult carer's needs under section 40 of the 2014 Act.

e. Local authorities did not have to comply with the duty under section 57 of the 2014 Act to provide an adult with his or her choice of accommodation.

f. Local authorities which met needs before carrying out a financial assessment could make a retrospective charge for meeting those needs (for an adult whose financial means were such that they may have been required to pay for or contribute towards the costs of their care) once it had completed an assessment.

642. As I have set out, with the implementation of the Coronavirus Act 2020, local authorities in Wales remained under a duty to meet needs to protect a person from experiencing or being at risk of abuse or neglect. Further, local authorities' duties under the European Convention on Human Rights also continued, including the right to life under Article 2, the right to freedom from inhuman and degrading treatment under Article 3, the right to private and family life under Article 8, and the right to enjoy rights and freedoms without discrimination, under Article 14. Local authorities' duties to promote well-being, as well as their general and specific over-arching duties under Part 2 of the 2014 Act and the associated Code of Practice, also remained in place. This included the duty to have regard to the UN Principles for Older People.

643. The Coronavirus Act 2020 also left unaltered the requirement in the Part 2 Code of Practice (General Functions) that "when exercising social services functions in relation to disabled people who need care and support and disabled carers who need support, local authorities would still be required to have due regard to the UN Convention on the Rights of Persons with Disabilities."

644. Against the above statutory background, the Coronavirus Act 2020 also allowed decisions to be taken regarding social care functions at local level, taking out intervening processes, in order to secure the prioritisation of services to address the most acute needs.

Consultation and engagement with stakeholders

645. Following publication of the Coronavirus Bill on 19 March 2020, Social Services and Integration Directorate policy officials provided verbal briefings to, and responded to questions from, the Social Care Planning and Response Sub-group on 27 March

2020. The discussion included the potential effect of the Coronavirus Bill provisions on local authorities' duties under the 2014 Act. I exhibit the circulated agenda at **AH2/456-INQ000500153** and the covering email at **AH2/457-INQ000500151**. A detailed note of the impact of the provisions was also circulated to the Group with permission to share more widely with any other stakeholders. I exhibit the note as **AH2/458-INQ000500160**. At the same time, stakeholders were also notified that the Welsh Government was giving urgent consideration to the need for Welsh Ministers to exercise their additional powers under the Bill to issue statutory guidance to local authorities on the application of the amendments to the 2014 Act.

646. Commencement of the Coronavirus Bill provisions was also discussed with the Group who confirmed that as the proposed amendments to the Social Services and Well-being (Wales) were not amongst those scheduled to come into force on Royal Assent, the Welsh Ministers should proceed to commence those amendments at the earliest opportunity.

647. Following the Deputy Minister for Health and Social Services's agreement, an urgent consultation subsequently took place on draft guidance with local authorities about the exercise of their functions under Parts 2 to 5 of the 2014 Act during the Covid-19 pandemic. I exhibit the Deputy Minister's agreement on 9 April 2020 to issue the consultation on the draft guidance as **AH2/459-INQ000500166**. The draft guidance set out how local authorities could use the modifications to the 2014 Act (principally in relation to assessing and meeting the needs of adults and adult carers) to ensure the best possible care for some of the most vulnerable people. The consultation on the draft guidance was issued on 9 April 2020 and stakeholders were invited to provide their comments by 17 April 2020. The response rate was positive and the feedback from those stakeholders subsequently informed an updated guidance together with a narrative summary of the changes, which were agreed by the Deputy Minister for Health and Social Services and published on or shortly after 1 May 2020. I exhibit the updated guidance with those modifications as **AH2/460-INQ000081088**.

648. To mitigate any unintended consequences of developing policy and consulting stakeholders in relation to that policy at such pace, Social Services and Integration Directorate policy officials indicated their intention to keep the guidance under review informed by the development of the Covid-19 pandemic and any impact arising from implementation of the amendments to the 2014 Act.

Suspension and expiration of social care provisions

649. On 2 October 2020, in line with the commitment to keep arrangements under review, Social Services and Integration Directorate policy officials formally invited evidence and views from stakeholders across Wales as part of a Rapid Review to inform Welsh Ministers' decisions to maintain or suspend the provisions of section 15 of, and Part 2 to Schedule 12 to, the Coronavirus Act 2020. The deadline for responses was 2 November 2020.

650. On 4 December 2020 the Deputy Minister was provided with a Ministerial Advice to note and agree the summary of responses as part of the Rapid Review and to confirm whether to suspend, retain or expire early, the social care provisions of the Coronavirus Act 2020 in Wales. To assist in the decision-making, the advice highlighted that the Welsh Local Government Association had consistently reported that no local authority in Wales had needed to rely on the modified duties under the 2020 Act. The advice also set out the current position on service capacity and provision within the care sector with local authority weekly data as at week commencing 23 November 2020 indicating that 59% of local authorities reported as GREEN in terms of their ability to operate; 50% local authorities reported as GREEN in relation to residential home capacity; 50% local authorities reported as GREEN care at home capacity. The advice also included anecdotal information which suggested that 37% of domiciliary care services reported Covid-19 in staff or clients, with 20% absence rates amongst some care providers. I exhibit the Ministerial Advice as **AH2/461-INQ000144934**. On 7 December 2020, the Deputy Minister subsequently agreed to suspend those provisions, and I exhibit that agreement at **AH2/462-INQ000500293**.

651. Following the Deputy Minister's decision to suspend the provisions, Social Services and Integration Directorate officials wrote to all respondents to the Rapid Review and other stakeholders across Wales that the Deputy Minister for Health and Social Services had noted that a majority of responses were in favour of suspending the social care provisions of the 2020 Act. It was also observed that even at the height of the pandemic local authorities did not implement the modifications introduced by the Coronavirus Act 2020. As a result, officials confirmed they had been asked to prepare the necessary legislation to suspend the modifications to the Social Services

and Well-being Wales Act 2014 as soon as reasonably possible, with the clear expectation that the regulations suspending the modifications would be laid in the first quarter of 2021. I exhibit the email to respondents to the Rapid Review as **AH2/463-INQ000353205** and the attached letter as **AH2/464-INQ000353207**. The Deputy Minister issued a Written Statement in relation to the suspension which was published on 19 February 2021. I exhibit the Ministerial Advice to approve the Written Statement as **AH2/465-INQ000116686** and the published statement is exhibited at **AH2/466-INQ000350676**.

652. On 12 March 2021, Social Services and Integration Directorate officials invited the Deputy Minister to agree to sign the draft regulations suspending section 15 of, and Part 2 of Schedule 12 to, the Coronavirus Act 2020 in line with her instructions which reflected the responses to the Rapid Review. I exhibit the Ministerial Advice as **AH2/467-INQ000136847**. The Coronavirus Act 2020 (Suspension: Local Authority Care and Support) (Wales) Regulations 2021 came into force on 22 March 2021. The ensuing decision of the early expiration of section 15 of, and Part 2 of Schedule 12 to, the Coronavirus Act 2020, was approved by the Deputy Minister in June 2021. The advice acknowledged that the UK Government had laid draft regulations to expire the equivalent provisions for England. I exhibit the Ministerial Advice at **AH2/468-INQ000353248** and the Deputy Minister's approval at **AH2/469-INQ000275765**.

653. The Coronavirus Act 2020 (Early Expiry: Local Authority Care and Support) (Wales) Regulations 2021 which allowed the early expiry of specified provisions in the Coronavirus Act 2020 came into force on 31 July 2021.

Regulatory regime

654. In addition to Social Services and Integration Directorate's involvement in the Coronavirus Act 2020, and the easements made to the Social Services and Well-being (Wales) Act 2014, the Directorate also advised Ministers to make certain amendments to the adult social care regulatory regime. The amendments to regulations were made through the Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) (Coronavirus) Regulations 2020, which amended the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 ("the 2017 Regulations").

655. The changes made to the 2017 Regulations, included:

i. Creating extra capacity within the system by permitting the establishment of emergency Covid-19-related residential and domiciliary care services for adults without requiring registration through the normal route.

ii. Measures to address the anticipated need for workers within the adult social care sector by relaxing specified requirements on service providers to undertake certain pre-employment checks on workers in care home services provided wholly or mainly to adults, or domiciliary support services provided for adults.

iii. Creating further capacity by relaxing conditions which limit the number of adults which may be accommodated in shared rooms in care homes for adults. To enable providers of care home services to vary their registration to exceed 15% of the total number of adults accommodated by the service in shared rooms, where accommodation needed to be provided because of the spread of coronavirus.

656. These provisions were developed at pace and as such a short consultation with key stakeholders was undertaken between 3 and 17 April 2020. The amending regulations came into effect in early June 2020. The provisions were subsequently revoked in 2022. At each stage the proposals were supported by advice to the Deputy Minister for Health and Social Services, which was discussed with me as needed. I exhibit the email seeking the Minister's approval to lay the regulations at **AH2/470-INQ000253590**. I also exhibit the accompanying documents which included the Ministerial Advice as **AH2/471-INQ000136782**, the draft explanatory memorandum as **AH2/472-INQ000253595**, and the statement on consultation as **AH2/473-INQ000253597**.

657. In terms of non-legislative easements, such as the decision to pause routine inspections of regulated services on 16 March 2020, the Social Services and Integration Directorate did not play the same role as it did when changes to the regulatory regime were required through amending regulations as described above. The decision to pause routine inspections was made by Care Inspectorate Wales as part of its role as the regulator of those services. Although my Directorate did not have any regulatory functions in relation to social care, these being entirely discharged by Care Inspectorate Wales, I was fully appraised of the decision to pause routine inspections, and I exhibit an email containing informal advice which was circulated by Care Inspectorate Wales colleagues to the Deputy Minister of which I was a recipient at **AH2/474-INQ000198265**. The advice explains that despite pausing routine inspections, the Inspectorate would still continue to inspect any service where there

were significant concerns about the safety and well-being of people, and that it would also continue to consider the need for inspection in relation to other concerns that had been raised.

658. The decision was made to ensure local authorities and care service providers could focus their resources on maintaining the health and safety of people using services and their staff at that time. Care Inspectorate Wales's key priority however was to continue to provide assurance to the public and Ministers regarding the safety of services. I also exhibit an email from a Social Services and Integration Directorate official summarising the list of easements both legislative and non-legislative of the regulatory regimes and the decision by Care Inspectorate Wales to pause inspections, and these recommendations were subsequently agreed by Ministers at **AH2/475-INQ000144799**.

659. I understand Care Inspectorate Wales has also prepared a statement addressing the easements made to the regulatory regime, including the decision to pause routine inspections.

Do Not Attempt Cardio-pulmonary Resuscitation notices ("DNACPR")

660. I am asked to comment on the Health and Social Services Group's involvement in the development of policy and guidance in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and notices. I am aware that parts of the Group outside my own Directorate were closely involved in these matters, but I and my team had only very limited involvement. In this section of my statement, I have therefore relied upon information provided by policy officials in response to Rule 9 requests made under Module 3 of the Inquiry including Frank Atherton (Chief Medical Officer) and Chris Jones (Deputy Chief Medical Officer).

661. Wales has its own clinical policy for DNACPR entitled *'Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales'*. This All-Wales policy for adults was launched in February 2015 and was revised and updated in 2017 and again in 2020. The Advance Future Care Planning Strategic Group reviews and updates this policy every two years, most recently in April 2022. The Strategic Group was established to sit under the NHS Wales End of Life Care Board and the Deputy Chief Medical Officer (Wales). Its

purpose is to provide clear leadership and strategic direction for all aspects of Advance Future Care Planning. Social Services and Integration Directorate is not represented on either Advance Future Care Planning Strategic Group or the End of Life Care Board and is not involved in their activities.

662. The clinical policy on DNACPR that was in place at the start of the pandemic was the 2017 version and is exhibited in **AH2/476–INQ000227411.** The policy in place between 2020 and 2022 is exhibited in **AH2/477-INQ000283301**.[31] The core principles underlying the guidance remain the same, but the updated policy included additional resources for patients and their loved ones considering DNACPR and additional detail in relation to the All-Wales DNACPR form, how DNACPR discussions should be conducted, who should have those discussions, principles from relevant legal decisions, the requirements and responsibilities of the senior responsible clinician with oversight, and organ donation.

663. I understand that on 24 March 2020, Dr Mark Taubert, Chair of the Advance Future Care Planning Strategic Group, contacted the Deputy Chief Medical Officer (Wales) proposing that a Covid-19 update was necessary, given that patients who developed Covid-19 deteriorated very quickly, and many were likely to not have had discussions about CPR, or which treatments they would and would not want. The Deputy Chief Medical Officer (Wales) agreed to this course of action and the proposed wording which would be discussed with the Strategic Group. On 28 March 2020 Dr Mark Taubert and the Clinical Lead of the End of Life Care Implementation Board wrote to all Medical Directors, Nursing Directors and the Welsh Ambulance Service Trust to confirm that the All Wales DNACPR policy was being reviewed. However, recognising that there were significant concerns about acute situations that could arise where no prior DNACPR or advanced future care plan existed, an emergency update was issued by letter. A copy of this letter, the wording of which was agreed with the Deputy Chief Medical Officer (Wales) is exhibited **AH2/478-INQ000226990**. The key passages of the emergency update to the policy provided:

> *"[T]he COVID-19 pandemic presents exceptional circumstances. The difficulty foreseeing a patient's illness and the risk of sudden deterioration mean that for some people it will not have been possible to get a decision discussed and signed off by a clinician physically at a patient's bedside, before their*

[31] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry.

heart/breathing stops, even if the patient has previously expressed that they would refuse any future CPR. As regulators, including the Nursing and Midwifery Council have acknowledged, exceptional circumstances can mean that the usual rules and practices do not work. During the pandemic it may not be possible to discuss decisions and explore views with a patient. Delirium is common in this disease. It may not have been possible to consult family members/proxy (because of isolation and, in times of crisis, extreme pressure of work) as would normally be expected, but attempts to do so should be timed, dated and annotated. It is accepted that even if these things are not possible, CPR should not be done if it would not work, particularly given the harm it would cause.

For patients with severe COVID-19 infection with no treatment options to reverse the disease, or who are known not to want escalation, CPR offers no benefit. In the exceptional circumstances of the current pandemic, clinicians of all professions may try to secure a doctor's decision not to attempt CPR. But we must recognise that this may not be possible. ***Such clinicians, at the coalface of clinical decision making, should not perform CPR that will not work, and that will cause harm to the patient, resuscitators and bystanders, even if no DNACPR decision has been recorded in advance. They should be supported in deciding not to do so. Such a decision should be rapidly discussed with fellow attendees at the scene of an acute deterioration where there is no DNACPR or ACP in place, agreed and recorded very clearly in contemporaneous notes.*** *An informed and balanced decision to withhold CPR, as has been made abundantly clear in our All Wales DNACPR Policy, does not preclude the individual from other forms of treatment if they are needed, or from maximum comfort measures and dedicated care that places dignity as a top priority, and these should be continued in all circumstances."* [emphasis in original]

664. Understandably, those working on the frontline in the healthcare system were concerned about decision making around DNACPR, particularly in challenging situations on the frontline. A Ministerial Briefing dated 9 April 2020 on palliative and end of life care, a copy of which is exhibited in **AH2/479-INQ000361494,** provided a summary of the initial steps taken in Wales and the policy at the time. This included that the direction that decisions on DNACPR should not be made just because an individual was an older person, was considered vulnerable or living with a disability,

and that it was necessary to reassure people falling into these categories; while recognising that ventilation and CPR were aggressive treatments that could cause real harm as well as benefit, and that they should be used when there was the prospect that they would help a person to survive, keeping in mind the potential harms. I was not copied into this briefing when it was initially circulated.

665. The Covid-19 Moral and Ethical Advisory Group Wales (to which I have briefly referred earlier in my statement) was convened to consider and advise the Chief Medical Officer (Wales) and Ministers on moral and ethical issues in the collective response to the pandemic across public services in Wales. Its Terms of Reference are exhibited at **AH2/007-INQ000066079**. I was not a member of this group, but I am aware that membership included Martyn Jones, interim chair of the Equality and Human Rights Commission Wales Committee, Rhian Davies from Disability Wales, and Helena Herklots, Older People's Commissioner for Wales.

666. The Covid-19 Moral and Ethical Advisory Group developed a framework of values and principles for healthcare delivery in Wales which was sent out to all health board Chief Executives, Medical Directors, Directors of Nursing and Directors of Therapies and Healthcare Scientists on 12 April 2020. This was not specific to decisions around DNACPR in particular, but I mention it because it informed the approach taken to the delivery of healthcare during the pandemic generally. A copy of this letter and the framework is exhibited in **AH2/480-INQ000300105,** and a Written Statement was published on 14 April 2020, exhibited at **AH2/481-INQ000349329**. The framework described equal concern and respect as the core value to inform planning and decision-making in health care delivery. This meant that everyone mattered equally, the interests of each person were the concern of all of us and of our society, and the harm that might be suffered by everyone person matters. The framework also defined further principles to underpin the ethical delivery of health care: respect, minimising the overall harm from the pandemic, fairness, working together, reciprocity, keeping things in proportion, flexibility, and good decision-making.

Concerns about DNACPRs

667. I am asked to summarise concerns brought to the attention of the Health and Social Services Group about the use of DNACPRs.

668. I understand that early in the pandemic, concerns were raised about a letter issued by a GP surgery in Bridgend to vulnerable patients, inviting them to sign

DNACPR agreements. This led to the statement issued by the Older Person's Commissioner on 1 April 2020 expressing understandable concern. I exhibit the statement at **AH2/482-INQ000181737**.

669. This was not the only concern around inappropriate use of DNACPRs raised with the Welsh Government. On 6 April 2020, I was one of the recipients of an email sent by Gillian Baranski, Chief Inspector at Care Inspectorate Wales, in which she forwarded details of an incident at a care home regarding the death of a resident for whom a DNACPR had been in place and who had not been admitted into hospital as a result, and in which the Chief Inspector raised a series of questions, including whether care home residents and their families properly understood the implications of a DNACPR. I exhibit that email at **AH2/483-INQ000500163**.

670. On 7 April 2020, I was copied into the Chief Nursing Officer Wales's reply to Gillian Baranski. The Chief Nursing Officer (Wales) confirmed that her team had followed up with the particular care home involved in this incident and explained that there was work being carried out for the provision of palliative medicines in the community: **AH2/484-INQ000412478**. The Chief Medical Officer (Wales) also attached guidance that had been published by the Royal College of General Practitioners, in conjunction with the NHS in Wales, on how to have sensitive conversations with patients most vulnerable to Covid-19, including in relation to advance care planning CPR: **AH2/485-INQ000412481**. I understand that this guidance had been circulated by the Royal College to GP surgeries the previous day, in response to the concerns that had been raised by the Older People's Commissioner regarding the letter issued by the Bridgend GP surgery: **AH2/486-INQ000500161**.

671. Also on 7 April 2020, a joint statement was issued by the Older People's Commissioner along with other entities in the sector both here and in Scotland and Northern Ireland, raising concerns regarding "blanket decisions" regarding DNACPRs: **AH2/487-INQ000181738**.

672. Again, on 7 April 2020, the Chief Nursing Officer shared concerns raised by the All Wales Family Forum and Mencap that there was anxiety that the learning disability community may not be given clinical treatment or may be categorised as DNR, due to their learning disability. I understand that in response, an extant version of the easy read version of the DNACPR policy, including updates relating to Covid-19 was shared.

673. On 8 April 2020, a statement was issued by the Disability Wales Reference Group which raised concerns that the rights of disabled people were not always being upheld in the provision of healthcare services: **AH2/488-INQ000276264**[32].

674. In response to these concerns, on 17 April 2020, the Chief Medical Officer (Wales) and Chief Nursing Officer (Wales) issued a joint letter to all health boards regarding decisions on DNACPRs. The letter was intended to ensure that there was clarity around ethical decision making for people with protected characteristics under the Equality Act 2010, including age, vulnerability, physical or learning disability, autism, other life-long illnesses or conditions such as cerebral palsy, enduring mental health conditions or substance misuse problems. A copy of this letter is exhibited in **AH2/489-INQ000300106**. The letter made it clear that age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes. It emphasised that decisions should be made on an individual and consultative basis with people. It made it clear that it was unacceptable for advance care plans, with or without DNACPR form completion, to be applied to groups of people of any description. The Chief Medical Officer (Wales) and Chief Nursing Officer (Wales) noted that whilst they were not aware that DNACPR decisions were being made purely on the basis of an individual's age, having a disability, learning disability, autism, mental illness or other condition, it was important in such difficult and anxious times to provide some measure of reassurance to those individuals living with these conditions and their loved ones.

675. The letter also highlighted concerns that had been raised about how the Clinical Frailty Scale might be used inappropriately in making decisions on escalation of care and DNACPR. It noted that that NICE had issued guidance (COVID-19 rapid guideline: critical care in adults – NICE guideline [NG159]) on 20 March 2020, and updated 9 April 2020 (and I understand that a link to the updated NICE guideline had been circulated by the Welsh Government to primary care coordinators, along with the Primary & Community Covid-19 Framework, on 8 April 2020: **AH2/490-INQ000227039**). The updated NICE guideline specifically advised that the Rockwood Clinical Frailty Scale was not validated in, and should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism.

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[32] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000500165]*

676. Care Inspectorate Wales and Healthcare Inspectorate Wales also issued a joint statement on 21 April 2020 on advance care planning, re-emphasising that all discussions about DNACPR needed to be compassionate and personalised, with decisions always made on an individual basis. A copy of this letter is exhibited in **AH2/491-INQ000227432.**

677. Later in the pandemic, the Chief Medical Officer (Wales) and Chief Nursing Officer (Wales) wrote again on 10 March 2021 to health board Chief Executives, medical directors, directors of nursing and directors of therapies and healthcare scientists, further to reports in the media that inappropriate DNACPR forms had been issued to people with learning disabilities in England. The letter re-emphasised information provided in the letter of 17 April 2020, that age, disability or long-term health conditions would not be factored when making the decision on DNACPR in Wales, and that this decision relied solely on the patient and/or their families. The letter is exhibited at **AH2/492-INQ000227370**.

678. I have also been made aware of a further issue that came to the Welsh Government's attention regarding DNACPRs after this, in March 2022, when Mencap reported to the Welsh Government's Learning Disability Ministerial Advisory Group that there had been an attempt to issue a DNACPR in the Hywel Dda Health Board in respect of a 63-year old individual with Down's syndrome purely on the basis that they were disabled and when this had been refused by the individual. Mencap reported that their service manager had been able to resolve the situation but was concerned about the approach adopted by the hospital. I exhibit the email to the Welsh Government from Mencap as **AH2/493-INQ000501655**.

679. I understand that, as a result of these concerns, on 14 April 2022 the Welsh Government issued a letter to the Hywel Dda Health Board as well as a general letter that was sent to all health boards reminding them of the guidance set out in the Chief Medical Officer (Wales) and Chief Nursing Officer (Wales)'s joint letters of 17 April 2020 and 10 March 2021, and a letter to the Academy of Medical Royal Colleges Wales asking for their support in spreading this message amongst their member colleges. I exhibit a copy of the letter sent to Hywel Dda as **AH2/494-INQ000227368**; the letter to all health boards is at **AH2/495-INQ000412593**; and the letter sent to the Academy of Royal College is at **AH2/496-INQ000501714**.

680. I exhibit the replies that were received from Betsi Cadwaladr University Health Board **AH2/497-INQ000500349**, from Aneurin Bevan University Health Board **AH2/498-INQ000501659,** from Velindre University NHS Trust **AH2/499-INQ000501715** and from Hywel Dda **AH2/500-INQ000499754**.

Further review of use of DNACPRs in Wales

681. The Welsh Government was aware of the Care Quality Commission's (CQC) review into the use of DNACPRs during the pandemic commissioned in October 2020, and the subsequent report published in March 2021. The Care Quality Commission oversees NHS England services and does not undertake any reviews in Wales, so the recommendations from its pandemic report cover the very diverse services and trusts in England. I am informed that there is no single DNACPR policy in England but different policies within different trusts, so a comparison between the Welsh and English policies cannot easily be made.

682. Whilst the Care Quality Commission does not make recommendations for Wales, the outcome of the review in England was incorporated into discussions within national groups, such as the NHS Wales Palliative & End of Life Care Programme Board and as part of the routine two-yearly review of DNACPR policy (which has taken place in 2020 and 2022). The British Medical Association Ethics Committee was also drafted into a wider stakeholder event, to ensure that any subsequent policy versions included up-to-date information.

683. In addition, several reviews have now taken place of DNACPR practices in Wales, focusing on adherence of clinicians and health boards to the All-Wales policy. This has included an All-Wales Thematic Review on DNACPR undertaken by the Mortality Review Working Group, which looked into each health board's practices and principles regarding DNACPR, and collated examples of practice. This review led to recommendations for a range of stakeholders, including health boards and the Welsh Government. Furthermore, Health Inspectorate Wales has made DNACPR inspections a key part of its inspection processes, and has undertaken a Wales-wide DNACPR review, which was published on 23 May 2024: **AH2/501-INQ000485929.**

Monitoring of deaths in care homes

684. The Welsh Government received data collected by Care Inspectorate Wales on the number of deaths of care home residents during the pandemic. All deaths of care home residents are required to be notified to Care Inspectorate Wales as regulator, and the Welsh Government had access to this information from the Inspectorate from early in the pandemic.

685. From 15 March 2020, Care Inspectorate Wales produced a daily report (working days) to monitor the number of cases of Covid-19 being notified to it, which was shared with the Welsh Government, and which came to include notification of deaths as well as cases.

686. In addition, during the week beginning 16 March 2020, the Covid-19 Data and Intelligence team was established by Care Inspectorate Wales to monitor incoming notifications in relation to cases (residents or staff) in social care services. The Covid-19 Data and Intelligence team included representatives from Care Inspectorate Wales's data analyst team, inspectors and Welsh Government Knowledge and Analytical Services statisticians. By 18 March 2020, the team was producing the 'Coronavirus Notifications Report' report daily (seven days a week), giving details of suspected and confirmed cases notified to Care Inspectorate Wales, and, in time, including charts showing total deaths and Covid-19 related deaths notified to Care Inspectorate Wales. These reports were shared with Social Services and Integration Directorate's Social Care Co-ordination Hub and others within the Welsh Government. An example of the fully developed report is exhibited at **AH2/502-INQ000198645**.

687. On 15 April 2020, Care Inspectorate Wales generated its first daily report detailing notifications received from providers of the deaths of care home residents, called 'Care Home Deaths Report'. This reported on the total number of deaths notified to the Inspectorate each day and was circulated to the Health and Social Services Group, to the Welsh Government Knowledge and Analytical Services Covid-19 team, and to the Technical Advisory Cell. The report is exhibited at **AH2/503-INQ000198634**.

688. From 30 April 2020, Knowledge and Analytical Services began to include Care Inspectorate Wales data in the Covid-19 Data Monitor (which was the compendium of Covid-19-related data that was compiled and circulated within the Welsh Government,

initially on a twice-weekly basis). Knowledge and Analytical Services and Care Inspectorate Wales commenced publication of the data from 5 May 2020. I exhibit the published data at **AH2/504-INQ000353032**.

689. Knowledge and Analytical Services also shared the data directly with the Office of National Statistics to support publication of data relating to mortality in care homes. I understand that the Office of National Statistics began to publish Covid-19 mortality data that was broken down by place of death (rather than giving global figures for Covid-19-related deaths) from 7 April 2020, which captured deaths registered up to the week ending 27 March 2020. The Office of National Statistics also periodically published analysis of deaths of care home residents, who may have died in a care home, hospital, or elsewhere.

690. I am also aware that the Deputy Minister for Health and Social Services discussed the latest data on care home deaths in her regular meetings with Care Inspectorate Wales throughout the pandemic.

Challenges with relevant data

691. I am aware that, in the first months of the pandemic, Care Inspectorate Wales was not able to collect information about the ethnicity or protected characteristics of the individuals who had died. From late August 2020, information about age, gender, learning disability and autism was collected as part of the death notification information that was provided to Care Inspectorate Wales, although it was not possible to carry out any detailed analysis of this data because the equivalent data relating to all residents living in care homes was not held.

692. I am also aware that the data that Care Inspectorate Wales was able to collect was dependent on care home providers complying with the notification requirements. While there was confidence that compliance was reasonably good, it was of course not possible to guarantee that every death or confirmed case of Covid-19 in social care was notified, particularly given the extreme pressure that providers were under at the time. It was also the case that providers received requests for data and information from a number of organisations during this period, including Public Health Wales, which added to this pressure and administrative burden.

693. Another significant caveat was that, in the early stages between 12 March 2020 and 19 August 2020, providers were not only notifying Care Inspectorate Wales of deaths of people with confirmed Covid-19 but also suspected cases.

694. I am also aware that there was initially a lack of information on the number of vacant places in care homes. The Welsh Government's Care Home Capacity Tracker, which as I have explained in the Hospital Discharge Decisions section of this statement, was still in development at the start of the pandemic and went live on 26 March 2020. As I also stated earlier, in the initial stages, a significant number of providers either were not using the tool or were not updating the information, and so this was of limited value. However, by June 2022 approximately 80% of the older adult care home providers were registered with the Tracker.

Care home closures

695. I am asked to provide information about how many care homes closed during the relevant period, with a summary of the reason for the closure. The information in the table below has been provided by the Care Inspectorate Wales.

Reason for closure	Number
Lack of staff	1
Financial viability	16
Could not contain outbreaks and/or sufficiently implement IPC measures	1
Retirement	6
Unknown	6
Issues with lease/ premises	8
Provider health issues	3
Non operational - did not re-register after introduction of RISCA. Therefore registration cancelled.	2

Decommissioned	1
Change of service type	2
Cancelled - Enforced	2
Voluntary cancelled - Unable to meet required standards - in enforcement processes with CIW	3
Total	**51**

Social care worker ID cards

696. I have been asked specifically about social care worker ID cards. I understand this scheme was introduced by Social Care Wales to provide social care workers with proof of eligibility for things like key worker shopping slots and so on. There had been plans for such cards to be introduced before the pandemic, and when Covid-19 emerged, these were expedited with the cards being introduced in, to the best of my knowledge, March or April 2020. I understand that there was some discussion of this between Social Services and Integration Directorate officials and Social Care Wales before the scheme was introduced. The Welsh Government was supportive of the scheme but was not any more involved in it than this.

Recruitment of social care staff during the pandemic

697. I am asked to confirm whether there were any initiatives regarding early graduation or registration of medical students that were relevant to the adult social care sector, which there were not.

698. I am also asked whether there were any initiatives regarding the re-employment of retired or returning workers who could be deployed in the adult social care sector. On 20 March 2020, Social Services and Integration Directorate officials advised the Deputy Minister for Health and Social Services that there was a good case for extending the timeframe within which care workers must be registered with Social Care Wales after entering employment, from six months to 12 months: **AH2/505-INQ000097598**. The Deputy Minister agreed this recommendation, which was intended to facilitate the considerable expansion of the workforce necessary in response to the pandemic. The advice also noted that Social Care Wales was

intending to allow continued access to the "confirmed competence" route to registration during the mandatory phase, which would mean that returning or retired workers would be able to register once confirmed by their manager.

699. In August 2021, the Minister for Health and Social Care agreed recommendations for a funding package of £160,000 to support a recruitment campaign for social care, in recognition of staffing shortages which were particularly apparent in domiciliary care: **AH2/506-INQ000501638**. This funding allowed TV advertising over a three-week period in August and September of 2021, which was reported as leading to an increase in visits to the WeCare.Wales online jobs portal, and a 27% rise in the number of job applications made through the website. A request for further funding of £305,000, to continue this recruitment drive into October to December 2021 was made to Ministers in October 2021: **AH2/079-INQ000176883**.

Lessons learned

700. I have included as an Appendix to this witness statement a table setting out a list of all lessons learned exercises in which the Welsh Government was involved that touch on the adult social care sector during the pandemic, alongside a summary of any recommended actions and Welsh Government's response. Some of these exercises and reports were solely focused on adult social care and others were broader in scope but made findings relevant to adult social care, which have been noted on the table.

Recommendations

701. The Chair has asked me to consider recommendations in order to improve the response of the adult social care sector in the event of a future pandemic. The social care sector went into the pandemic in a fragile state. Demographic changes and increased complex care demand at a time of financial hardship meant services were already stretched and the nature of adult social care meant a wide range of providers were operating withing the sector. Added to this, the sector has an undervalued workforce, by society in general, and whilst it has a totally dedicated and committed workforce, it is poorly remunerated, leading to high turnover. This impacts on the ability of people to receive continuity of carers. The fragmented nature of adult social care leads to data challenges especially in the ability to operate in a real time data

context. My general sense is whilst reform is necessary and is a much-needed part of the solution, the sector requires financial investment on a par with the NHS. The social care sector is an important part of the foundational economy. I make the following observations and recommendations.

702. Stabilised care sector: Ensure that the adult social care sector has the necessary resources to provide a more resilient and responsive social care system. Engagement with the social care sector, its workforce, service users and their carers via the National Office for Care and Support continues to highlight the need for a long-term sustainable funding solution for social care, as we look to develop a National Care and Support Service that not only meets the needs of the sector but delivers for the people of Wales. Our long-term plans for the National Care Service recognise the value of social care in Wales and the importance of a vibrant and thriving system; a system which provides excellent quality care, supports its workforce and rewards work, and is closely integrated with the NHS and the broader public sector. We remain committed to our long-term vision, but also recognise a balance must be struck between immediate financial pressures and long-term sustainable solutions, particularly within the current challenging context we find ourselves in. Importantly, consideration must be given, both in the immediate and long-term, to ensuring the necessary resources are in place to have a more resilient and responsive social care system. As part of the development of the National Care Service, research will soon be commissioned to explore the funding position across the sector and what is needed to work towards a system which is free at the point of need.

703. Workforce terms and conditions: Social care continues to face significant workforce challenges with recruitment and retention in particular. The result during the pandemic was a shortfall in the workforce required as social care workers needed to take necessary sick leave with limited staff available to cover. These challenges have continued since the pandemic. Social care is competing with sectors such as retail and hospitality in terms of pay, which are offering more pay for less intensive roles. Substantial work is ongoing to address the different challenges facing social care workers. The Social Care Fair Work Forum, a social partnership group in which trade unions, employers and Government have come together, continues to consider how we can improve the terms and conditions of social care workers in Wales. In the short term, the Forum has focused its efforts on improvements to pay and has provided advice on how we take forward the Real Living Wage. The Forum has since been focusing on its wider priorities including the development of a draft Pay and

Progression framework aiming to provide more consistent pay, progression and development opportunities. The Forum has also initiated a 'Social Care Workforce Partnership', a unique model which will ultimately incorporate many Fair Work elements currently being progressed by the Forum. Improved pay, terms and conditions would attract more people to the social care workforce which would clearly be an advantage when responding to any future pandemics.

704. As highlighted in this statement, testing capacity often constrained our ability to offer much needed protections and assurances to care workers, workplaces, those receiving care, and the general public during the pandemic. Testing capacity should always be fully utilised and cover the social care workforce as a standard approach. Whilst I recognise that establishing testing infrastructure for a novel virus will inevitably take time for research and development, it is essential that we work towards ensuring that sufficient testing capacity can be quickly established in the event of a future pandemic, e.g. by enabling test processing laboratories to be quickly stood up at scale once novel tests are available.

705. Social Care Data and Evidence: The Welsh Government has been working to improve the collection of social care data to develop a clearer picture of service delivery and to support the Chief Social Care Officer in championing a stronger voice for the sector. This data will enable a better understanding of the sector within Wales that can inform decision making as part of future national emergencies.

706. Emergency Planning and Risk Assurance: Enhanced / dedicated resource to improve resilience across the social care sector and not an 'add on' to the day job.

707. A more recognised role for professional judgement alongside scientific evidence and advice. By way of example, as evidenced in this statement, professional judgement meant that Social Services and Integration Directorate advocated for testing for domiciliary care workers at a time when it was not considered a priority by Welsh Government scientific advisors, for it to later be agreed to when the capacity/evidence allowed.

Statement of Truth

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

Signed: Personal Data

Appendix: Module 6 reviews, lessons learnt and reports

Report Recommendations/Lessons Learned addressed to the Welsh Government relevant to the scope of Module 6	*Welsh Government response to the recommendations, actions and future plans (where relevant)*
Social Services and Integration Directorate Covid-19 Pandemic Lessons learned Report AH2/507-INQ000338686 This report is a summary of the "lessons learned" documents authored by leaders of Covid related workstreams that were stood up within Social Services and Integration Directorate over the course of the pandemic, as well as workshop discussions held with policy leads in November and December 2022. The report contains a summary of positive experiences and lessons and those where further work to implement the learning would be beneficial. It also makes a series of recommendations to ensure this learning is maintained in everyday business and the way in which we respond in the future to incidents of the same or a lesser scale. Key themes from the report and further actions: 1. Joined up working 2. Resources and capacity 3. Data 4. Clarity of scope/roles 5. decision making 6. Well-being and flexible working	
Recommendation 1d: Social care policy colleagues to be included as primary partners in related policy discussions, particularly regarding covid "stable"	Since policy functions have re-centralised, this has led to challenges in ensuring social care has appropriate input into future arrangements. Felt that social care input is sometimes included within wider health care decision making but without necessary representation or contribution from social care policy colleagues, which does not always reflect the specific needs of the social care sector. This has created a lack of clarity for some about the Directorate options for moving pandemic related work towards a covid stable approach. It was felt that proactive engagement with social care policy colleagues may result in a more appropriate or targeted sector specific approaches.
Recommendation 2c: Enhance the social care coordination Hub resource and develop a discrete work programme that can be easily	Having deputy director leadership and oversight of the response activity was a major component of its success, along with the establishment of a Hub team.

paused, enabling it to act as a central co-ordination team for major incident response.	
Recommendation 2d: Consider how Social Services and Integration Directorate can ensure it is able to resource teams to support an emergency response alongside respecting and responding to the role of Senedd members.	The theme of resources and capacity appears to have been one of the most challenging during the pandemic, noting the difficulty in securing team resource to take pandemic work forward. There was discussion round increased volume of work to respond to the pandemic alongside equally important requirement for the heightened levels of democratic scrutiny from Members of the Senedd and their role to both hold the government to account and to protect and inform their constituents.
Social Services and Integration Directorate Covid 19 Pandemic Lessons Learned: Stakeholders Report AH2/508-INQ000501713 This report contains a summary of the feedback along with a range of recommendations to ensure this learning is maintained in everyday business and that the way in which we respond to incidents of the same or lesser scale is improved. The report explores examples of what went well, and what didn't work well, specifically Welsh Government's work with stakeholders on the publication of policy guidance, communications across providers and social care and healthcare synergies.	
Recommendation 7b: Aligned with recommendation 2c in the main report enhance the social care coordination Hub resource to ensure increased capacity for emergency planning preparations within SSID as part of its regular business	Welsh Government was praised for its ability to take full control and charge of the situation at pace. The approach to individuals making themselves available to carry out specific tasks was highlighted as a positive.
Recommendation 11a: Welsh Government to continue its work on greater health and social care alignment by implementing its "A healthier Wales: Our plan for health and social care" strategy	

01/07/2020- Health, Social Care & Sport Committee – Inquiry into the impact of Covid-19 outbreak and its management on health and social care in Wales: Report 1
AH2/509-INQ000349686

The Committee issued an open call for evidence and conducted a survey in order to better understand the challenges for those working on the frontline and those whose health or care needs had been directly or indirectly affected by Covid-19. The Committee invited views in writing and conducted a series of oral evidence gathering sessions.

The report committee made 28 recommendations, including the following recommendations relevant to adult social care.

Recommendation 9. The Welsh Government must ensure that all patients being discharged from hospital directly into a care home have been tested in accordance with latest best practice to ensure maximum protection for residents and staff.	**Response:** 'accepted' The Welsh Government's test strategy published on 15 July, in order to safeguard those residents currently living in care homes, all potential new residents and all patients being discharged to a care home or a hospice from hospital will continue to be tested before admission into a care home. For people being discharged from hospital, test results must be available prior to discharge. We have also established an additional discharge pathway for people who test positive or are still infectious; they will go to step-down care to be cared for and will be tested again to ensure a negative test result before returning to their care home.
Recommendation 10. The Welsh Government must ensure that: ▪ testing within care homes takes place on a regular and systematic basis, ▪ such tests are administered by suitably trained individuals rather than using home testing kits and ▪ sufficient capacity is available to support both of the above	**Response**: Accept in principle/ reject/ accept **Accept in principle**: o Regular and systematic testing in care homes in Wales and all residents and staff in care homes were tested during May and June. o Policy to test all care home staff on a weekly basis was introduced, which was extended from an initial period of four weeks to eight weeks. o Minister for Health and Social Services indicated that the frequency of testing care home staff would be reduced to fortnightly if prevalence rates remained low. o Results of the testing have been closely monitored and prevalence rates have remained low. However, as part of developing a more targeted and differentiated approach to testing, where prevalence remains high or we see a spike,

	more regular, systematic testing may be maintained or reintroduced. o Testing must have a 'clear purpose' and regular and systematic testing in care homes must be informed by analysis of scientific evidence and consideration of levels of vulnerability and risk of transmission. However, work will continue to support, train and advise care homes on testing and on infection control measures. ▪ **Reject**: - o Local health boards have provided training for administering tests using home testing kits and extensive guidance is available via gov.wales. o Home testing kits delivered to care homes as testing satellites have provided an effective and flexible approach that meets the particular needs of care homes. ▪ **Accept**: o Sufficient capacity in Welsh labs and the UK Lighthouse labs to enable testing in care homes in Wales. o Repeat testing occurs via the Lighthouse labs model through home testing kits. o Where incidents occur (2 or more positive cases) then we utilise Public Health Wales labs and sampling routes where sampling is administered by trained individuals to support outbreak management. This enables a more flexible, responsive approach to outbreaks supporting the Test Trace Protect process

December 2020- Health, Social Care & Sport Committee – Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales: report 2 - Impact on mental health and wellbeing AH2/510-INQ000066499	
Recommendation 14. The Welsh Government should continue working with partners to develop longer term innovative approaches to facilitate indoor visits to care homes.	**Response: Accepted** o The Welsh Government's Coronavirus Control Plan provides guidance on what each Alert Level meant for care home visiting. o Risk-assessed visits within a visitor pod or similar structure (which includes a complete physical

	barrier between the visitor and resident), are permitted for designated visitors and indoor visits in exceptional circumstances including, but not restricted to end of life, remain permitted. o The Welsh Government's pilot to provide temporary visitor pods to adult care homes continues with an additional order of visitor pods secured, reaching the pilot aim. Feedback to be collected from those homes supplied with a pod as part of the evaluation of the pilot. o Welsh Government allocated up to £1 million funding in this financial year for providers who have sourced their own visiting pods. o As part of the 'care home residents' wellbeing' element of the care homes action plan we have asked Age Cymru, All Wales People First and Voices from Care to engage with people living in care homes around what in particular has supported their well-being during the pandemic.
March 2021- Health, Social Care & Sport Committee: Inquiry into the impact of COVID-19 outbreak and its management on health and social care in Wales: Report 3 - Impact on the social care sector and unpaid carers AH2/511-INQ000066515	
Recommendation 1 The Welsh Government must, as an urgent priority, ensure that care homes have access to all the necessary equipment and facilities (e.g. pods and lateral flow testing for visitors) to enable visits to be resumed	**Response**: Accept Welsh Government worked with care home sector stakeholders to ensure homes were supported to resume visiting, for example, developing visiting guidance to help care home providers plan for risk assessed visits and providing direct financial support to assist providers with the costs of accommodating visits. The Deputy Minister for Health and Social Services announced a pilot of care home visitor pods on 23 November to support Covid-secure visiting installed in care homes across Wales. Providers received support with the costs associated with accommodating Covid-secure visits including contribution towards staff time in facilitating visits. Welsh Government made £3,045,000 available to care homes via the hardship fund which included a contributory payment towards the additional staff costs associated with the lateral flow device. Financial support was further extended between April- June 2021.

Recommendation 2 The Welsh Government must, as a matter of urgency, strengthen its guidance to care home providers to ensure that allowing safe visits becomes the default position	**Response**: Accept The Welsh Government continue to work closely with stakeholders through Care Inspectorate Wales's stakeholder care homes visiting group and keep its care home visiting guidance under close review. Version 6 of the guidance (published on 23 March) sets out a range of mitigations homes can take to reduce this risk and is clear in stating that '*we expect and encourage providers to facilitate visits wherever possible to do so, in a risk managed way*'. Albert Heaney, Deputy Director General and Dr Frank Atherton, Chief Medical Officer also wrote to care home providers reinforcing Public Health Wales's advice that there is no compelling public health reason to wait until all residents (and/or staff) had completed both doses of the vaccine before resuming indoor visits. It concluded by emphasising that the expectation was that the vast majority of care homes would now be resuming regular, risk-assessed indoor visiting, unless there were exceptional circumstances which would mean this cannot take place.
Recommendation 3 The Welsh Government should work with Care Forum Wales to gain and maintain a clear picture of the position across Wales with regard to care home visits on an ongoing basis, and to facilitate the sharing of good practice between care homes with a view to increasing the number of homes that are supporting safe visits.	**Response**: Accept The Welsh Government continues to monitor the position on care home visiting across Wales. The Welsh Government's regular residential care home group meeting attended by Public Health Wales, Care Inspectorate Wales and Local Authority and Health Board Environmental Health Officer (EHO) colleagues, is also a key mechanism for monitoring progress on visiting. CIW has also reinforced the Welsh Government position on visiting and sets out the importance of visiting and cautions against blanket visiting bans.
Recommendation 4: The Welsh Government should write to all health boards to re-emphasise their responsibilities on hospital discharge and the procedures	**Response**: Accept The need to ensure that vulnerable people do not remain in hospital beds when they no longer need medical interventions has been a constant focus of the Welsh Government's guidance on patient discharge.

that must be followed in the event of an unsafe discharge taking place	Safely transferring people out of hospital beds and into more appropriate care settings was central to the COVID-19 Hospital Discharge Services (Wales) guidance (issued April 2020) which was updated in December to reflect advice from TAG in relation to infectivity. Wrote to all partners to emphasise the need to discharge patients safely, in compliance with the guidance. Conducted a survey to gauge the impact of the guidance.
Recommendation 5 The Welsh Government should monitor the turnaround times for test results for care home staff and residents to ensure results are received as soon as possible. This should ideally be within 24 hours of testing, and certainly not later than 48 hours	**Response**: Accept in principle Welsh government will continue to assess the system with the Department for Health and Social Care and Public Health Wales and will make necessary improvements to ensure performance is maintained and improved.
Recommendation 7 The Welsh Government should set out how the work being undertaken by Social Care Wales to professionalise the social care workforce will secure parity of esteem with the health care workforce, and the establishment of clear and properly-remunerated career pathways for social care workers	**Response**: Accept We recognised the need for parity of esteem between health and social care professionals which requires support for training, development and services available to the workforce. The joint social care Wales and health education improvement Wales workforce strategy for health and social care was launched and sets out a joint ambition for a health and social care workforce. Registration with social care Wales ensures greater consistency regarding qualifications and evidence of skills, providing assurance on the quality of care. The social care fair work forum brings together government, employers and unions to define fair work and how it should be applied for social workers in Wales. The Wecare.Wales campaign led by social care Wales reached out across a range of platforms and has been adopted by all seven regional partnerships and the materials are being used to promote roles in social care across Wales.

	Social Care Wales has made available a package of wellbeing support for social care workers including access to mental health services and an employee assistance scheme.
Recommendation 10 The Welsh Government must ensure sustainable funding for young carer services and prioritise the safe re-opening of face-to-face support for young and young adult carers	**Response**: Accept in principle Responsibility for provision of young carer services rests with local authorities. Welsh Government has continued to place health and social care at the top of its priorities with local authorities receiving billions from the Welsh Government in core revenue support grants and non-domestic rates to spend on key services. New strategy for unpaid carers launches in March 2021 affirming Welsh government's commitment to improving the recognition of and support for unpaid carers. Resumption of face to face support for young and young adult carers sits with local authorities.
Recommendation 11 The Welsh Government should reconsider its response to Recommendation 26 of our report into the impact of the Social Services and Well-being (Wales) Act 2014 in relation to carers—which called on the Welsh Government to provide long-term, sustainable and streamlined funding for third sector organisations delivering essential services to carers—with a view to implementing it as a matter of urgency.	**Response**: Accept in principle The promised longer-term comprehensive spending review was delayed due to the pandemic. Welsh Government greatly values the support provided to unpaid career by third sector organisations, however Welsh Government funding to the third sector concentrates on providing additionality to statutory services. The responsibility for the delivery of essential services to unpaid carers rests with the local authorities. Welsh government continues to fund a diverse range of organisations that supports the implementation and embedding of the key principles of the 2014 Act. The integrated care fund is another source of support for unpaid carers.

Recommendation 12 The Welsh Government should ensure that its communication and public awareness campaigns in respect of the COVID-19 vaccination programme includes effective targeting of information for unpaid carers, and makes sure that they are aware of their eligibility for vaccination	**Response**: Accept A detailed communications and engagement strategy to promote uptake of the vaccination among all those eligible is in place, and Welsh Government will continue to work closely with stakeholders to understand the needs of audiences and how best to reach them. We recognise the need to ensure as many unpaid carers as possible know they are eligible for a vaccination as part of priority group 6. From March 2021 unpaid carers who were not already registered as an unpaid carer with their GP have been able to fill in an online self-referral form hosted by each local health board. Welsh Government worked closely with Carers Wales, Carers Trust Wales, All Wales Forum of Parents and Carers to develop guidance regarding the Covid-19 vaccination of eligible unpaid carers as part of priority group 6.
Recommendation 13 The Welsh Government should work with its partners to develop and implement an awareness-raising campaign to improve knowledge about the support available to carers, particularly in respect of financial support. This should include ensuring that people who have been identified as unpaid carers during the COVID-19 vaccination programme have access to information about their rights and the support they are entitled to	**Response**: Accept Welsh Government has allocated £100,000 to Carers Wales and Carers Trust Wales to develop and deliver an awareness-raising campaign to improve knowledge about the support available to unpaid carers and their rights under the Social Services and Well-being (Wales) Act. Welsh Government are working to increase the take-up and raise awareness 13 of entitlements in accessing both devolved / non-devolved benefits. The Welsh Government accepts that more needs to be done to improve the take-up of both devolved and non-devolved welfare benefits and that this should be addressed through cross-government approaches and by joint working with local authorities and other key partners. A Wider Income Maximisation and Benefit Take-up Working Group has since been established with the aim to promote and support a sustained increase in the take up of devolved and non-devolved welfare benefits and welfare payments. The Welsh Government ran a National Welfare Benefit Take-up Campaign from 1 March to 25 March 2021 to

	encourage people to check and claim the benefits they are entitled to. The campaign targeted low-income families across Wales as well as a wider audience of people who may now need support due to the financial impacts of the pandemic. In conjunction with the National Campaign Welsh Government are also taking forward, Frontline Worker Awareness Raising and Targeted Welfare Benefit Advice and Support. The unpaid carer self-referral form has been designed for the specific purpose of registering eligible unpaid carers for the Covid-19 vaccine under Priority Group 6. Carers Trust Wales and Carers Wales are currently working in partnership to transform carer recognition, respect and support across health and social care settings in Wales. This three year "Carer Aware" project is funded via the Sustainable Social Services Third Sector Grant and aims to strengthen and enhance implementation of the Social Services and Well-being (Wales) Act 2014 by raising awareness of unpaid carers and the impact of caring, with the general public and relevant professionals.
Recommendation 14 The Welsh Government should undertake equality impact assessments of decisions taken during the COVID-19 pandemic in respect of support/funding for unpaid carers to ensure that no groups or communities are being disproportionately impacted in the short or longer term	**Response**: Accept Mindful of the requirement to comply with its statutory duties, including the Public Sector Equality Duty, Welsh Government undertook a comprehensive equality impact assessment (EIA) of the Strategy for Unpaid Carers which was drafted during the pandemic via engagement with stakeholders and a public consultation.
Recommendation 15 The Welsh Government should make a statement early in the Sixth Senedd on its proposals to strengthen the arrangements for the social care sector and the outcome of the consultation on its	**Response**: Accept in principle It will be for the next Welsh Government to determine how to engage with the Senedd Health Committees on this matter. Officials are in the process of summarising the consultation responses to the White Paper: Rebalancing care and support. This summary will be published on the Welsh Government website within 12 weeks of the consultation closing. It will be important

White Paper: Rebalancing care and support, and how it will take account of relevant recommendations made by this and previous Senedd Health Committees.	for the incoming Government to consider the consultation responses and all other available evidence, including recommendations from this and previous Senedd Health Committees, to make a clear statement of proposals to strengthen the arrangements for the social care sector early in the Sixth Senedd.
Welsh Government Internal Audit report: December 2021- Social Care AH2/039 – INQ000022606 The Welsh Government's internal audit service carried out an audit into the pandemic response and plans for future recovery relating to adult social care in Wales. The report concluded that management could take reasonable assurance that arrangements to secure governance, risk management and internal control were suitably designed and applied effectively. The report identified one significant finding (in relation to document retention), set out below.	
4.1: Workstreams – Document Retention Workstreams were established at pace to respond to the demands of Covid-19, covering areas such as Care Homes, PPE & Procurement and Workforce capacity and well-being. Our review of the remit of these workstreams identified the following issues: a) Each workstream is required to complete a chronological log detailing the work completed and decisions taken. The logs are a key tool in evidencing actions taken over the pandemic period and will be relied upon to inform a future inquiry. However, not all logs had been maintained as required. b) Completed workstreams are required to prepare a legacy	Throughout the pandemic, SSID has developed and maintained comprehensive records of the significant amount of work undertaken to support social care services in Wales. Staff within SSID continue to be actively engaged in the delivery of Covid-19 response measures, which we recognise has meant that some of the chronology logs have become out of date and some legacy reports for work-streams that have become business as usual have not yet been undertaken. The Social Care Coordination Hub has already commenced a review of chronology logs and legacy reports and are working to support policy leads to ensure documentation is kept up to date.

statement detailing any outstanding issues and where responsibility for their resolution lies. The statement should also include any lessons learnt to ensure good practice was shared. However, not all legacy statements had been fully completed at the time of the audit, although an exercise is ongoing to undertake a full stocktake exercise.	
<u>01/04/22- Health & Social Care Committee report – Waiting well? The impact of the waiting times backlog on people in Wales AH2/512-INQ000066519</u> This Senedd Committee report focused on the impact of the waiting times backlog on people who are waiting. In producing the report, interviews and focus groups were held with people waiting for diagnosis or treatment, or caring for people who are. Evidence was also gathered in writing and by holding oral evidence sessions with stakeholders, including the Minister and the Chief Executive of NHS Wales.	
Recommendation 10: The Minister for Health and Social Services should provide an update on the appointment of the national clinical leads for pain management. This should include information about their role in ensuring the appropriate use of pain medication in the management of people on waiting lists, including their contribution to managing the risks associated with the prescription of opiates	**Accept:** Welsh Government has published guidance, Living with Persistent Pain in Wales (gov.wales), advising both health and social care professionals and those living with persistent pain about the different approaches available for the management of persistent pain
Recommendation 16: The Minister for Health and Social Services should outline her expectations for the involvement of carers and families in care and treatment planning, and how any reduction of their involvement during the pandemic will be reversed.	**Accept:** The Health and Social Care Regional Integration Fund (the RIF) is a 5 year fund to deliver a programme of change from 1st April 2022 to 31st March 2027. The RIF builds on the learning and progress made under the previous Integrated Care Fund (ICF) and Transformation Fund (TF), however it is a new fund and will seek to create sustainable system change through the integration of health and social care services to deliver

	new models of care by the end of the five year programme.
Recommendation 18. The Minister for Health and Social Services and Digital Health and Care Wales should work with health and social care services, including primary and community services, to ensure that all health and social services have appropriate access to shared patient records.	Accept: The National Data Resource (NDR) will provide the digital architecture to underpin a single national health and care record. Digital Health and Care Wales (DHCW) is delivering the NDR programme with NHS Wales stakeholders and local government representatives, such as Social Care Wales, which has recently developed a memorandum of understanding with the NDR programme and DHCW to recognise their strategic relationship The Welsh Community Care Information System (WCCIS) was set up as a single community care digital platform across Health Boards and Local Authorities in Wales to make sharing of data between health and social care organisations more efficient. Welsh Government remains firmly committed to the goal of a joined up health and care system, allowing the sharing of patient/service user records between health and social care organisations and across geographic borders within Wales. The Welsh Patient Administration System (WPAS) will allow wider record sharing across a substantially larger number of care settings i.e. records from social care feeding into GP and hospital systems, together with reciprocal flows of information.
Audit Wales: 18.03.21- Test, Trace, Protect in Wales: An overview of progress to date AH2/513-INQ000066525 The report sets out the main findings from the Auditor General's review of how public services are responding to the challenges of delivering Test Trace Protect services in Wales.	
Observation: Report analyses tests reported including care home staff and care home residents.	

Audit Wales: 13.04.21- Procuring and Supplying PPE for the Covid-19 Pandemic AH2/514-INQ000066524 The report looks at the procurement and supply of Personal Protective Equipment (PPE) during the Covid-19 pandemic.	
Observation: The report discusses how Councils and private care homes were primarily securing PPE for themselves individually or as part of regional arrangements and in the first two weeks 11% of care home providers and 18% of domiciliary care providers said they had insufficient PPE.	N/A

Audit Wales: 10.06.21- Rollout of the COVID-19 vaccination programme in Wales AH2/515-INQ000066528 The report considers the rollout of the vaccination programme in Wales and looks at the key milestones for the vaccination programme. It was the aim to offer first dose vaccination to all care home residents and staff by mid-February 2021	
Observation: The report discusses health boards using outreach models to vaccinate in care homes and temporary and mobile hubs. Furthermore, Welsh Government took steps to contact care homes to ensure all staff and residents had been offered a vaccination.	

Audit Wales: 14.09.21- Picture of Public Services 2021 AH2/516-INQ000066529 The Report summarises some key trends in public finances and sets out our independent perspective on some of the key issues for future service delivery

Observation: The report discusses the challenges of rising demand, particularly from older people and children's services, are compounded by low financial margins in care homes for older people.	

<u>01/09/21- Internal Audit Report 376: Nosocomial Transmissions Group AH2/517-INQ000022598</u> The scope and purpose of the audit was to review: -actions taken by WG including the Nosocomial Transmission Group (NTG) in providing guidance to hospitals and other healthcare settings on Covid-19; - monitoring mechanism in place to ensure the effective implementation of guidance provided; and - the extent to which WG have learnt and disseminated lessons from other health departments both in the UK and internationally.	
Observation: The term "nosocomial" usually refers to hospital acquired disease where a positive test has been identified 7 days or more after hospital admission. During the Covid-19 pandemic, the NTG agreed that this should be expanded to include any closed environment - such as care homes and residential centres. The purpose of the NTG is to provide advice, guidance and leadership for all healthcare and care settings including hospitals, primary and community care, registered care homes.	

Internal Audit report: September 2021- Performance Management of Mental Health delivery plan AH2/518-INQ000022601	
Observation: The plan sets out outcomes based upon overarching themes, including strengthening co-production and supporting carers. The report includes actions regarding how we will support carers and the third sector to play a role in shaping, delivering and evaluating services, through better links with local, regional and national networks.	

Internal Audit report: May 2022- Covid-19 Vaccination programme AH2/519-INQ000022611	
Observation: audit finding and management update, Health Boards have also been asked to plan the following based on the latest data and advice from the JCVI on the trajectory of the virus whilst retaining the flexibility to 'surge'. The surge included an urgent Spring booster for over 65's, care home residents	

and those aged 16 and above who fall in clinical risk groups.	

M6-HSSG-01 – Exhibit Schedule

Paragraph Number	Exhibit number	Inquiry ID
25	AH2/001	INQ000495978
28	AH2/002	INQ000502005
31	AH2/003	INQ000083226
37	AH2/004	INQ000066130
40	AH2/005	INQ000068498
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52	AH2/007	INQ000066079
54	AH2/008	INQ000081000
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60	AH2/012	INQ000227420
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687	AH2/503	INQ000198634

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Lessons Learned (Appendix)		
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	AH2/512	INQ000066519
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