Witness Name: Andrew Evans

Statement No.: M2B 1

Exhibits: 34

Dated: 13 October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ANDREW EVANS

I, Andrew Evans, will say as follows: -

Preface

1. The purpose of this statement is to assist the Inquiry to investigate key government decision making within the Welsh Government, the information relevant to such decisions and the role of senior officials and advisers.

2. My response to the Inquiry's request for evidence made under rule 9 of the Inquiry Rules 2006, referenced M2B/WG/AE/01, will cover the period from the 1 March 2020 and May 2022 (which I will refer to in this statement as "the pandemic period") and the information provided in this statement is structured as follows:

    a. **Part A** – will provide an overview of my role as Chief Pharmaceutical Officer (Wales).

    b. **Part B** – will provide information and responses spanning the whole of the pandemic period.

3. In order to fully address the Inquiry's request for evidence, I have relied largely on my personal recollection of events as they occurred supported by reference to email exchanges with colleagues, letters issued in my name or those of my immediate reports, and saved copies of briefings, presentations, and other documents.

Background and qualifications

4. I am a senior pharmacist and public health specialist with more than 20 years professional experience having graduated with a degree in pharmacy from the University of Bath in 1999 and joining the register then maintained by the Royal Pharmaceutical Society of Great Britain and subsequently the General Pharmaceutical Council, in August 2000. After registration I completed a diploma in clinical pharmacy at Keele University in 2003 and a master's degree in public health (MPH) at the School of Medicine at Cardiff University in 2014. I have been the Chief Pharmaceutical Officer at the Welsh Government since January 2016 appointed initially on an interim basis following the retirement of the previous Chief Pharmaceutical Officer, and substantively since August 2017.

5. Between April 2012 and December 2016, I was the Principal Pharmacist for Public Health and Primary Care at Public Health Wales NHS Trust and the Welsh Government, responsible for providing expert professional advice to Ministers, the Welsh Government, and NHS organisations in Wales, on all aspects of pharmaceutical public health, primary care pharmacy and prescribing policy.

6. Between May 2006 and March 2012 I was employed by Cardiff Local Health Board and its successor organisation Cardiff and Vale University Local Health Board in a number of roles including as a prescribing advisor providing advice to general practitioners on safe and effective prescribing of medicines; Head of Performance and Modernisation leading on business planning and performance management of organisations commissioned to provide services on behalf of the health board; and programme lead ensuring high cost medicines recommended by the National Institute for Health and Care Excellence, were made available and being used effectively.

7. Between July 2005 and May 2006, I worked a Community Pharmacy Facilitator at Bristol North Primary Care Trust providing advice and support to community pharmacies within the trust's area.

8. Between August 1999 and July 2005, I worked for Boots the Chemists in store, regional and head office roles including a period of two years between August 2003 and July 2005 as an education and training pharmacist based at the School of Pharmacy and Pharmaceutical Sciences at Cardiff University.

9. At various times up to 2010, I worked periodically as a locum pharmacist in community pharmacies, a GP practice pharmacist and pharmacy post graduate education tutor.

10. I am an honorary lecturer at the School of Pharmacy and Pharmaceutical Sciences at Cardiff University and have research interests in a range of areas including the contribution of community pharmacies to promoting and protecting public health, the safe and effective use of medicines, and the role of point of care testing in promoting antimicrobial stewardship.

My role as Chief Pharmaceutical Officer for Wales

11. As Chief Pharmaceutical Officer I am the Welsh Government's principal advisor on all aspects of pharmacy practice, prescribing and medicines related issues. I am expected to lead strategic development and provide exemplary, impartial, and authoritative advice across Welsh Government and NHS Wales in a range of areas including medicines-related regulation, prescribing and therapeutics, policy development and improvements in pharmacy practice which underpin the implementation of the Government's objectives to improve the health and wellbeing of the people of Wales. Specifically, I provide independent, impartial advice on pharmaceutical matters associated with (a) provision of healthcare, (b) public health, and (c) safety of medicines and medicines legislation to the Welsh Government, other Government Departments and NHS Wales; national leadership and oversight of prescribing quality, safety and expenditure; professional direction for the development of national contractual arrangements for community pharmacy; act as sponsor of the All Wales Medicine Strategy Group to ensure people in Wales have equitable and prompt access to new and innovative medicines, and clinicians have access to authoritative advice on the safe and effective prescribing and use of medicines; and provide strategic advice and leadership to developments across the pharmacy profession in areas including but not limited to digital health and care, workforce development and education reform.

12. I did not hold any other positions within the Welsh Government, or elsewhere, during the pandemic.

13. Broadly my role remained the same during the pandemic although in common with others, it was necessary to prioritise my work to matters directly related to the pandemic response. My primary roles during the pandemic can be summarised as follows:

    a. Ensuring patients continued to receive medicines necessary for the treatment and management of non-Covid-19 conditions reflecting the changing delivery of healthcare during the pandemic;

    b. Ensuring access to the community pharmacy network in Wales was maintained both to provide access to prescribed medicines and to reduce avoidable pressure on other NHS services for example hospital emergency departments, whilst protecting the safety of those working in pharmacies;

    c. Ensuring continuity of access to medicines essential for the treatment (including palliative treatment) of Covid-19;

    d. Working with the UK Therapeutics Task Force, RAPID C-19 group, and National Expert Working Groups to ensure repurposed medicines identified as beneficial in the treatment or prophylaxis of Covid-19 were promptly made available in Wales;

    e. Working with the UK Vaccine Task Force, the Medicines and Healthcare products Regulatory Agency, and manufacturers to secure adequate and timely supply of Covid-19 vaccine for Wales and leading the development of supply chains for the deployment of vaccines in Wales taking account of specific statutory, storage, and handling requirements, and the requirements of good distribution practice; and

    f. Working with the UK Antiviral Task Force and National Expert Working Groups to ensure patients had access to novel antiviral medicines for the treatment of Covid-19 and being the senior responsible owner for the deployment of antiviral treatments in Wales.

14. I was not professionally involved in the lockdown decisions made by the Welsh Government during the initial stages of the pandemic. Nor was I involved in decision making in relation to international travel and border control.

15. My only involvement in the drafting of public health and coronavirus legislation and regulations was about the need for pharmacies to be permitted to remain open, subject to social distancing rules, in the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020[1] and for individuals to be permitted to leave their homes to collect medical supplies[2] but I was not involved in the broader discussions about or the drafting of these regulations, or other legislation.

Engagement within the Welsh Government

16. During the pandemic I was supported on matters relating to the continuity of supply of medicines, the deployment of repurposed medicines for treatment and prophylaxis, and antiviral deployment by NR, All Wales Specialist Pharmacist for Contingency Planning.

17. I was supported by Name Redacted formerly Head of Pharmacy and Prescribing branch at the Welsh Government, on matters related to community pharmacy, and NR Deputy Chief Pharmaceutical Officer, on all matters related to the Covid-19 vaccination programme.

18. In addition to the support provided by these individuals I received support from the All-Wales Therapeutics and Toxicology Centre on the development and dissemination of therapeutic advice related both to the treatment of Covid-19 and to the management of other clinical conditions during the pandemic, and from the Welsh Medicines Advice Service on Covid-19 vaccination and antiviral deployment.

19. Over the course of the pandemic, I interacted with very many officials across the Welsh Government, most frequently including:

    a. Dr Frank Atherton, Chief Medical Officer for Wales in relation to Covid-19 therapies;

[1] See Regulation 6(2)
[2] See Regulation 8(1)(a)

b. Dr Mark Walker, Senior Medical Officer for Primary Care in relation to shielding and primary care;

c. Frances Duffy, Director of Primary Care and Health Science in relation to primary care;

d. Dr Chris Jones, Deputy Chief Medical Officer for Wales in relation to Covid therapies;

e. NR Nursing Officer Primary & Integrated Care in relation to primary and community care;

f. Dr Gill Richardson, Senior Professional Advisor and then later Deputy Chief Medical Officer for Vaccination on the vaccine development programme;

g. Claire Rowlands, Interim Director of Vaccine on the vaccine development programme;

h. Elin Gwynedd, Deputy Director on the vaccine development programme

i. NR Deputy Chief Pharmaceutical Officer on the vaccine development programme;

j. Samia Edmonds, Planning Programme Director in relation to operational issues concerning medicines shortages in critical care; and

k. Andrew Sallows, NHS Delivery Director, who worked closely with Samia, also in relation to medicines shortages in critical care.

20. I was in frequent contact with each of the officials named above, at various times speaking and emailing multiple times each day. There were many instances of positive working. This was exemplified by the working with colleagues on the vaccination programme with whom I met and emailed on a daily basis between autumn 2020 and summer 2021. In my experience there were few if any issues with working relationships within Welsh Government during the pandemic.

21. In general, I provide advice to the First Minister and the Welsh Ministers in a number of ways. Primarily my advice is provided under the cover of Ministerial Advice (MA) which either I have prepared or which has been prepared for me by my team to clear.

Typically these will be about matters directly related to pharmacy or prescribing policy, or which has been prepared by another policy area and on which I have been asked to provide specific professional advice because, for example, changes to the way services are delivered may have implications for how medicines are used in that service. I have attached a table of the ministerial advices prepared by me and my team in the relevant period as exhibit **AEM2BWG01/01-INQ000231326**.

22. In addition to formal advice issued under the cover of a MA, over the course of the pandemic I provided advice to the First Minister and the Welsh Ministers informally at briefing sessions or in response to emails from private offices. I do not recall providing any such advice directly to ministers during the period January to March 2020.

23. I am not aware of any occasions where the advice I gave, whether formally or informally, was not followed.

PART B

Initial Response to the pandemic January – March 2020

24. In the period between the beginning of January and the beginning of March 2020, I had become increasingly aware of the growing concern regarding Covid-19 and recall the first cases being identified in the UK in late January and in Wales on 28 February 2020. I do not recall the precise date on which I received this information nor whether I received it in my professional capacity or through the ministerial briefings.

25. Overall, I recall a heightening degree of concern about the seriousness of Covid-19 in the period January to March 2020, with the level of concern closely related to significant milestones in the course of the pandemic, for example the first UK cases, deaths, and first case in Wales all gave an increasing sense of concern.

26. In my own area of responsibility, my recollection was initially of the increasing seriousness of the implications of Covid-19 on medicine supply chains and the implications this had for the management of other health conditions, of concerns regarding the safety of some medicines (i.e. Non-Steroidal Anti Inflammatory Drugs) if taken whilst having Covid-19, queries regarding potentially protective medicines (e.g. hydroxychloroquine and ivermectin), and in March of rising workload pressure on community pharmacies. My overall reflection was of a significant increase in concern

only during March although I have no recollection of being involved in discussions about aspects of planning for Covid-19 outside areas of my professional responsibility and cannot therefore give a confident assessment of the mood within Welsh Government more generally.

27. I recall the main discussions regarding planning for Covid-19 in late February and early March were focused around issues of business continuity and the supply of medicines. As evidence emerged of increased supply requirements for supportive medicines, there were reductions in manufacturing capacity in countries affected by high case rates, and pressures on the global supply chains because of restrictions placed on the export of medicines in some countries. In response to this situation I prepared a letter to local health boards, NHS trusts, general practitioners and community pharmacies on 6 March 2020 (which issued on 9 March 2020) describing the measures the Welsh and UK Governments were taking to ensure ongoing supply of medicines at that time and stressing the importance of hospitals, GPs and community pharmacies continuing to act responsibly and avoiding taking any local action that might adversely affect the medicine supply chain. A copy of this letter is exhibited in **AEM2BWG01/02-INQ000231297.**

28. On 8 March 2020 I went on planned leave during which time I became aware of the first reports of deaths in the UK and reports of panic buying and increased demand on and queues outside community pharmacies as people sort to purchase over the counter medicines and have their regular or additional prescriptions dispensed. During this period a decision was taken to provide personal protective equipment to pharmacies. The Ministerial Statement to announce this is exhibited at **AEM2BWG01/03-INQ000231329.**

29. I sent an email to **Name Redacted** setting out a list of suggested measures which if implemented would reduce demand on community pharmacies and support business continuity. Unfortunately, this email cannot now be located. These measures were referred to in the Minister for Health and Social Services' written statement of 13 March 2020 (as exhibited in **AEM2BWG01/04-INQ000231263)** as "relaxation of contract and monitoring arrangements for GPs and primary care practitioners". After returning to the UK on 15 March 2020 and to work on 16 March the detail of contractual and financial relaxations were set out in a letter to community pharmacies dated 18 March

2020 including making £5.5m available to support free delivery of medicines to vulnerable patients. A copy of this letter is exhibited in **AEM2BWG01/05-INQ000080856**.

30. Despite the implementation of contract relaxations, it was apparent pharmacies continued to experience significantly elevated levels of demand and on 21 March 2020 I issued a subsequent letter confirming additional flexibilities for pharmacies to reduce their opening hours by opening to the public one hour later each morning and closing one hour earlier each evening. A copy of this letter is exhibited in **AEM2BWG01/06-INQ000231279.** I issued a further letter on 27 March 2020 confirming advance funding of approximately £50m to alleviate cash flow problems faced by many pharmacy contractors receiving unusually large wholesaler bills as a result of the increase in prescription volumes seen in March 2020. A copy of this letter is exhibited in **AEM2BWG01/07-INQ000231327.**

31. At this time, I recall receiving informal queries from clinicians relating to the use of medicines for the prophylaxis and treatment of Covid-19, whether taking some medicines increased the risk of severe illness from Covid-19, and the ongoing management of a range of health conditions affected by changes to the way care was being delivered. In response I commissioned the All-Wales Therapeutics and Toxicology Centre to develop the Covid Therapeutic hub providing a single place to visit for evidence-based information on the therapeutic management of Covid-19 and other health conditions during the pandemic. The hub went live on 25 March 2020 and an email confirming this is exhibited in **AEM2BWG01/08-INQ000231275.**

32. I also recall providing advice to substance misuse policy colleagues on proposed changes to the treatment of patients receiving opiate substitution therapy for problematic substance misuse to long-acting subcutaneous injections of buprenorphine which could be given at weekly or monthly, rather than daily, intervals. A copy of advice is exhibited in **AEM2BWG01/09-INQ000231276.** and Ministerial Advice MA/VG/1080/20 is exhibited in **AEM2BWG01/10-INQ000231296.**

33. On 19 March 2020, following a meeting with Chief Pharmacists from every health board and NHS trust in Wales, we commissioned the All-Wales Therapeutics and

Toxicology Centre to provide daily stock reports for 120 medicinal products used in critical care for every hospital. Exhibit **AEM2BWG01/11-INQ000231265** refers.

34. As the number of cases and deaths in the UK rose and demand for medicines used at the end of life increased, in the last week of March or first week of April 2020 I initiated a piece of work with a Military Assessment Team (MAT10) to scope the feasibility of implementing arrangements to improve resilience of arrangements for access to end of life medicines and help conserve limited supplies.

35. On 6 April 2020 I wrote to LHBs to explain the measures put in place to maximise the availability of priority medicines used in the ventilation of patients. A copy of the circular is exhibited in **AEM2BWG01/12-INQ000231332.**

36. The end-of-life Covid-19 medicines service to supply 'just in time' emergency medicine packs was launched in April 2020. On 30 April 2020, in order to further improve supply of end-of-life medicines I issued a Welsh Health Circular permitting the reuse of end-of-life medicines prescribed for patients in care homes and hospices by other patients at the home or hospice. A copy of the circular is exhibited in **AEM2BWG01/13-INQ000231284.**

Key Meetings

37. In my role as the Chief Pharmaceutical Officer for Wales I attended the following key groups and meetings at which the Welsh Government's Covid-19 response was discussed and developed:

    a. The Covid 19 home isolation and vulnerable people Group was chaired by Amelia John (Deputy Director for Housing). It had cross government representation and was used to establish arrangements for shopping and medicines deliveries, including the role volunteers. This group met weekly from March to June 2020. Minutes of the meeting of 23 March 2020 are exhibited at **AEM2BWG01/14-INQ000231274** A review of the schemes to provide medicines to the shielded is exhibited at **AEM2BWG01/15- INQ000231305**.

    b. The Maintaining Essential Services Group was established in April 2020, and met every 3 days or so initially before moving to weekly meetings, to focus on determining and maintaining the provision of services deemed to be essential.

An email of 23 April 2020 seeking input into the production of a Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID-19 Pandemic is exhibited in **AEM2BWG01/16-INQ000231280.** This included the provision of medications and supplies for the ongoing management of chronic diseases, including mental health conditions and the maintenance of community pharmacy services. A copy of the framework is exhibited in in **AEM2BWG01/17-INQ000231281.**

c. The Planning & Response; Primary & Community Covid-19 Sub-group which was established in March 2020 and was concerned with access to end-of-life medicines provided by WAST paramedics and end-of-life medicines service.

d. The Weekly Countermeasures Group was established in to ensure pandemic stocks are deployed according to the ministers agreement, to consider other demands for the release of the stock and advise accordingly, monitor resilience of business as usual stocks and identify issues to be addressed, consider the use of Brexit supplies to reinforce the response to Covid-19 and to ensure that members of the Group link with the UK and other supply networks. The Group reported directly to the Health and Social Services Planning and Response Group. I attended the initial meeting (see exhibit **AEM2BWG01/18-INQ000231264**) but thereafter NR (Welsh Government Pharmaceutical Officer), attended in my stead and reported back to me.

e. The Primary Care Recovery Oversight Group was established in June 2020.

f. The Wales Medicines Shortages Advisory Group existed prior to the pandemic but was utilised to conserve medicines supply for ICU.

g. A Four Nations Weekly Call was held from April 2020 onwards in order to discuss the Supply of Medicines & COVID-19. This was attended by representatives from DH Medicines Continuity of Supply Team, Fiona Taylor (Principal Pharmaceutical Officer for Northern Ireland) and/or Eimer Smyth (Northern Ireland Department of Health) and Alison Strath (Chief Pharmaceutical Officer at the Scottish Government). On behalf of the Welsh Government it was attended by either myself, NR or NR NR senior policy officer pharmacy and prescribing branch). I exhibit, by

way of example, the minutes from one such meeting dated 3 September 2020, **AEM2BWG01/19-INQ000231288** refers.

h. There were a number of UK Covid-19 Therapeutics Access and Policy groups in place from June 2020 which worked to reach agreement to UK wide access policies for COVID therapies throughout the pandemic;

i. A weekly call with the UK Chief Pharmaceutical Officers from March 2020;

j. The COVID Therapeutics Deployment Group(s) met initially fortnightly from October 2021 to focus on establishing a national antiviral service, the provision of PCR and LFD tests for vulnerable groups and digital identification processes, the frequency of meetings was subsequently reduced to monthly and then bimonthly;

k. The Vaccine Task Force met frequently until the vaccination programme commenced, with including a twice weekly call on vaccine supply and logistics leading up to and in the weeks and months following the 6 December 2020. This task force discussed the direct supply of Pfizer vaccine to Wales by Pfizer and decisions about delivery volumes and schedules for vaccines;

l. The COVID vaccination programme boards, various stakeholder fora, and a weekly pharmacy supply and logistics meeting to discuss shortening second dose interval to seven weeks in Feb 2021. Ministerial Advice I provided the Minister for Health and Social Services in MA/VG/0429/20 regarding COVID-19 vaccine: medium term supply forecast and implications for planning is exhibited at **AEM2BWG01/20- INQ000231293.**

Data/statistics

38. During the first wave of the pandemic the main sources of data and statistics collected related to stock of critical care medicines (120 lines) held by every hospital in Wales. We generated these statistics ourselves for management use but not for publication.

39. Working with experts from health boards and analysts at the All Wales Therapeutics and Toxicology Centre we were able to generate reports of daily stock holding, changes since the previous reporting period and estimates of number of days stock

holding per ICU bed occupied in so called critical care dashboard. An example of the Critical Care Medicines Dashboard of 21 April 2020 is exhibited in **AEM2BWG01/21-INQ000231322**, the Critical Care Medicines Dashboard Explanatory Note is exhibited in **AEM2BWG01/22-INQ000231323** and the Critical Care Medicines Position and Forecast 28 September 2020 is exhibited in **AEM2BWG01/23-INQ000231324.**

40. Throughout the pandemic we combined this data with ICU bed occupancy data provided by colleagues in Welsh Government (from daily sitreps provided by health boards) to identify those medicines at greatest risk of stock outs. A copy of the 2020 Securing Adequate Supplies of Covid-19 medicines log is exhibited in **AEM2BWG01/24-INQ000231328**, and to instigate corrective actions (e.g. mutual aid). The Medicines Supply and Mutual Aid dated 28 September 2020 is exhibited in **AEM2BWG01/25-INQ000231325**.

41. Later in the pandemic, I collected data on the number of non-hospitalised patients treated with Covid-19 antiviral medicines and neutralising monoclonal antibody therapies from weekly reports provided by each health board. This data was subsequently published monthly on StatsWales until March 2023. A copy of this data has been exported and is exhibited in **AEM2BWG01/26-INQ000231298.**

42. In general data collection was straightforward, access to a single source of hospital medicines data provided digitally by Digital Health and Care Wales meant it was relatively straightforward to understand the stock position for a large number of medicines on a daily basis and access to dedicated analytical resource facilitated robust reporting. We also had access to a secure online environment ("the vault") which allowed daily stock reports and the critical care dashboard to be shared with relevant teams in health boards. Reporting numbers of patients treated with antiviral medicines relied on manual reporting which led to occasional delays and data omissions however the relatively small number of patients treated meant such issues occurred infrequently.

43. I do not recall having routine access to specific modelling throughout the pandemic, although I recall seeing modelling data at various meetings I attended. I also received papers for the Technical Advisory Group (TAG). I regularly received data on projected case numbers and ICU bed occupancy from colleagues and I can recall specific

scenarios where modelling of projected Covid-19 infection was requested and provided later in the pandemic as part of my work on the provision of antiviral medicines for non-hospitalised patients.

44. Whilst I was able to ask questions of the Welsh Government for scientific data, statistics and modelling through the Technical Advisory Cell (TAC) and TAG, I am not aware I did so other than in relation to demand for ICU medicines and capacity planning for the deployment of antiviral medicines for non-hospitalised patients. An example of this is exhibited in **AEM2BWG01/27-INQ000228020.** I was also able to engage with the Wales Covid Evidence Centre through TAC in order to facilitate observational research into the effectiveness of antiviral deployment in Wales. On the occasions I needed modelling I was able to access it and do not recall any issues where adequate modelling support was not provided.

Non-Pharmaceutical Interventions

45. I was professionally involved in the provision of information, and professional opinion and advice concerning the imposition of, easing of, or exceptions to NPIs where these directly related to the provision of pharmaceutical services. This would have been limited to decisions to exclude community pharmacies from premises/businesses which had to close during lockdown, implementing social distancing measures in community pharmacies, and the provision and use of personal protective equipment and face coverings in pharmacies. My role would have been limited to providing professional advice on the risks associated with the provision of pharmacy services and the reasonableness of implementing infection prevention and control measures in pharmacies.

46. When providing the above advice or making decisions about NPIs we were aware when making these decisions that in general pharmacy users are older and sicker than the general population and that there was therefore an inherent vulnerability in those attending pharmacies. We were also aware pharmacies are more frequently located in more deprived communities and that Covid-19 infection had a disproportionate effect on people from lower socioeconomic groups.

47. I believe sufficient consideration was given in decision making in this about the impact that the decisions would have on at risk and vulnerable groups who are frequent users of pharmacies.

Engagement with UK Government and counterparts

48. I was engaged with officials from the UK Government and NHS England throughout the pandemic on a range of issues of common concern. This included many instances of positive co-working in the following areas:

    a. Management of supply shortages for end-of-life and critical care medicines;

    b. The procurement of a stockpile of critical care medicines;

    c. The development of UK wide clinical access policies for repurposed medicines used as Covid therapies (tocilizumab, sarilumab, dexamethasone, baricitinib, budesonide);

    d. The development of UK wide clinical access policies/decisions for novel therapies (remdesivir, molnupiravir, nirmatrelvir-ritonavir, ronapreve, sotrovimab, and Evusheld);

    e. The Covid vaccination programme.

49. In general engagement was very positive across all these areas with no specific engagement issues.

50. From near to the beginning of the pandemic, I met weekly with the Chief Pharmaceutical Officers for England, Scotland and Northern Ireland, meetings were informal and not minuted. My recollection is that a range of topical issues were discussed at various times and included but was not limited to provision of PPE to community pharmacies, continuity of supply of medicines particularly for end-of-life care and critical care, reuse of medicines, additional funding for community pharmacies, extemporaneous preparation of medicines for use in critical care, and COVID therapeutics.

51. I represented the Welsh Government interests on the Antivirals and Therapeutics Taskforce (established in April 2022) and its predecessors the Therapeutics Taskforce

(established in April 2020) and the Antivirals Taskforce (established in April 2021). The taskforce was responsible for identifying existing medicines which could be repurposed as potential COVID-19 therapeutics (therapeutics) and novel medicines developed specifically for the treatment of Covid-19 (antivirals) and assessing these through clinical trials. Regular weekly meetings were held between officials from the antiviral and therapeutics taskforce and officials from devolved governments. I also participated in the national expert groups on Covid therapeutics and gateway reviews for the antiviral deployment programme for non-hospitalised patients.

52. I, with other officials from Welsh Government, worked very closely with the Vaccine Taskforce, including participation in at least twice weekly calls to discuss vaccine allocations and delivery schedules, and weekly meetings on vaccine characteristics. In particular, I was accountable for establishment of the supply chain for Wales' vaccine programme taking account of the specific, often challenging, storage and handling requirements of novel vaccines. The Vaccine Taskforce was set up with the UK Government's Department for Business, Energy and Industrial Strategy (BEIS) to drive forward the development, production and deployment of a coronavirus vaccine as quickly as possible. From summer 2020 I worked intensively on the vaccination programme and developed an incredibly positive working relationship with officials of the Vaccine Taskforce to develop a robust supply and deployment model for Wales.

Informal communications

53. I did not use WhatsApp to communicate with my colleagues within the Welsh Government. I was a member of a WhatsApp messaging group with the other UK Chief Pharmaceutical Officers, Dr Keith Ridge CBE (NHS England), Dr Rose Marie Parr OBE (Scottish Government), and Cathy Harrison (Northern Ireland Executive). Drs Ridge and Parr have subsequently retired and been replaced in the group by David Webb and Alison Strath at NHS England and the Scottish Government respectively.

54. The messaging group was used to discuss a range of professional and sometime personal issues on an informal basis, it allowed us to communicate quickly and directly at a time when there was significant volumes of email correspondence and a faster response was required (often to check what was happening in one nation relative to

others). The group was also used to share views in meetings with a wider audience and to chat informally and provide a source of peer support.

55. I do not believe there was any significant divergence in approach between nations on matters related to pharmacy and prescribing. I had no involvement in decisions on divergence from the UK Government in relation to NPIs which applied differently in Wales to England including the decision relating to the firebreak.

Public Health communications

56. There were several occasions where I was involved in public health communications. These included developing messaging to support relieving pressure on community pharmacies during the early stages of the pandemic through the development of the "5 simple steps to help your pharmacy help you" messaging exhibited in **AEM2BWG01/28-INQ000231269**, the development "pharmacy open for you" materials exhibited in **AEM2BWG01/29-INQ000231304**, and the development of patient information about access to antiviral treatments including direct to patient letters and patient information leaflets exhibited in **AEM2BWG01/30-INQ000231330**, and **AEM2BWG01/31-INQ000231295.** I consider the 5 simple steps messaging worked particularly well with elements of the messaging being picked up by others including the Royal Pharmaceutical Society. I do not believe there were any areas in which I experienced obstacles or issues or where opportunities were missed.

Lessons learned

57. I do not hold a professional view about the Welsh Government's decisions on NPIs. In my personal view evidence supports the view that lockdowns and firebreaks proved to be effective public health measures to reduce the incidence and transmission of and mortality associated with, Covid infection. My overriding recollection is that the Welsh Government took more a cautious approach and applied NPIs more stringently, sooner and for longer than in England although my recollection is not complete and is garnered largely from media reporting at the time. From a personal perspective I was a citizen living in Wales throughout the pandemic and never felt the application of measures in Wales exceeded what was reasonable given the very real risks posed by Covid-19 both for individuals directly and indirectly through unbearable pressures on the NHS and other public services.

58. I did not play a role in assisting the Welsh Government to understand the international response to Covid-19 and am unable to comment on whether any lessons learned from other countries were implemented.

59. In relation to pharmacies and prescribing the Welsh Government applied lessons learned from decisions made at early stages in the pandemic to its response as the pandemic developed. Largely the actions proved to be effective in mitigating the challenges posed by the pandemic and included:

    a. Maintaining a range of contractual relaxations for pharmacies including reduced opening hours to support staff wellbeing and a focus on those pharmacy services which were most important to meet the needs of the population at the time;

    b. Continued provision of PPE to community pharmacies. A letter of 26 June 2020 regarding the use of PPE when delivering NHS Pharmacy Services is exhibited in **AEM2BWG01/32-INQ000231294**;

    c. Provision of IT support through access to video-consulting services and MS365 for pharmacists and pharmacy technicians;

    d. Continued use of community pharmacy escalation tool to identify demand/capacity pressures in pharmacies;

    e. Lessons learned from medicines deliveries using Royal Mail transferred to roll out antiviral medicines for Covid;

    f. Standardisation of end of life care medicines for initial just in time response;

    g. The continued use of the IT infrastructure and analytical capacity developed to monitor stock levels of critical care medicines and application of methodology to support continuity of access to Covid treatments in hospitals;

    h. Establishment of a Covid stockpile and plans to develop an operational buffer stock of essential medicines for use in NHS hospitals. A framework to support the availability of essential medicines as NHS Wales recommences routine care was published in June 2020 see exhibit **AEM2BWG01/33-INQ000227198**

and a cover letter regarding the availability of essential medicines for routine care exhibited in **AEM2BWG01/34-INQ000231331**;

i. Additional aseptic syringe filling capacity and establishment of the MHRA licensed "temporary medicines unit" by NHS Wales Shared Services Partnership provided long term resilience and capacity to produce ready to administer medicines after the first wave, saving clinical time and minimising waste of medicines in short supply;

j. Increased number of health boards with good distribution capability and authorised by MHRA to undertake wholesaler dealing allowing movement of medicines between health boards to support stock shortages/mutual aid;

k. Increased vaccine storage, handling, and distribution capability and capacity for medicines (and vaccines) needing to be stored at ultra-low and refrigerated temperatures;

l. Continued use of the Covid therapeutic hub.

60. The pandemic posed challenges to the arrangements in place for maintaining access to community pharmacies, for maintaining the supply chain for medicines, and for providing ready to administer injectable medicines. The increasing demand for aseptic medicine preparation for routine care and the growing shortfall in NHS aseptic medicine preparation capacity, was understood before the pandemic and a programme business case setting out plans for long term transformation of pharmacy technical services developed by the Transforming Access to Medicines Programme (which I chaired) had been submitted to the Welsh Government by the NHS Wales Shared Services Partnership in March 2020. In relation to access to pharmacies, the increased demand for prescriptions observed in March 2020 had not been anticipated and was compounded by the need to implement social distancing measures and high rates of absence as a result of Covid-19 infections amongst pharmacy staff. On supply chain resilience, the Welsh Government relied upon the UK Government's overall responsibility for maintaining continuity of supply of medicines to the UK. Much preparatory work had been done ahead of EU exit to minimise supply chain disruption including increasing the stock holding of many medicines by manufacturers in the UK.

This helped with the immediate supply challenges but with only limited impact on availability of critical care medicines.

61. In my opinion the key challenges faced by the Welsh Government were the severity of Covid-19 and the relatively high rate of severe illness, the lack of evidence or certainty of the effectiveness of interventions to curtail the spread of Covid-19 and the absence of effective treatment(s). These combined with the unprecedented pace at which case rates escalated, necessitated rapid and a highly adaptive approach to decision making. There were few or in most cases no obvious right choices, and there were equivocal arguments and significant opportunity costs associated with almost every decision. My recollection is that I felt there was little time to contemplate the majority of decisions because time lost in considering and appraising options meant the situation often deteriorated in the intervening period such that the planned intervention may no longer be beneficial. Furthermore, the options available to the Welsh Government were often constrained by issues outside its direct control such as global demand for medicines or PPE.

62. I recall in the main decision making was streamlined and appropriately delegated to senior officials, I felt empowered to make decisions about things within my areas of expertise and felt supported by my line manager and other directors and importantly by finance colleagues.

63. On more contentious matters such as procurement and data sharing, I recall feeling process and approvals took too long but with hindsight I now feel this was only relative to the pace at which policy decisions were being made at the time and on looking back decisions made on such matters were made quickly and important robustly given the complexity and risk associated with them.

64. There are no decisions within my areas of professional expertise where with hindsight I feel the wrong decision was made, particularly given the circumstances we found ourselves in, however, I do think there were areas where we might have done more or made different decisions had we known more about Covid-19 or had more resources available. For example, whilst we provided PPE in accordance with advice provided by what was then Public Health England at the time, with hindsight we would have considered providing greater quantities of PPE to pharmacies had there been

sufficient supplies. At the time however, the need of health and care workers in other settings was considered to be greater and ultimately decisions needed to be taken in a constrained environment within which limited supplies were available. In general, my and my team's approach was to go as far as we could as soon as we could. Using the example of relieving pressure on community pharmacies, we recognised that reduced access to GP services would result in a surge in demand for community pharmacy services and therefore our approach to contractual relaxations, and guaranteeing funding set out in my letter of 18 March 2020 was more comprehensive and provided greater security for the sector and in turn for patients, than a more incremental approach would have otherwise achieved.

65. I have reflected on whether in relation to continuity of supply of medicines whether we could have been better prepared, alongside the demand for prescriptions in primary care and the pressure this placed on community pharmacies, I recall my most significant concerns were related to what at the time felt like a very real risk we may simply run out of some medicines particularly those used in critical and end of life care. Once this risk was understood I believe good decisions were made in Wales and across the UK to mitigate risk including identifying clinically appropriate alternative treatments and procuring and building a Covid medicine stockpile, nevertheless the pandemic highlighted an over-reliance on just in time supply chains which could not meet the unprecedented level of global demand. Similarly, we had insufficient capacity to manufacture ready to administer medicines for use in critical care. This necessitated clinicians and nurses preparing medicines at the bedside with many hours of nursing and clinical time lost. A long term plan to increase our sterile manufacturing capacity had been agreed by the Welsh Ministers immediately before the pandemic and we took action to increase capacity after the first wave. With hindsight, as with other nations, we were starting behind where we could have been and had we been less reliant on the business as usual supply chains and had more production and wholesaling capacity going into the pandemic, we would have faced fewer challenges. We are taking steps to address this in the future.

Statement of Truth

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

Signed Personal Data

Dated: 13 October 2023