**Official Sensitive – Cabinet**
Not for publication

**COVID 19 – Core Group meeting:- Wednesday 24th June 2020 (08:30)**
**Caerdydd 1 &2 / Skype VMR meeting**

**Present -**

**Ministers:** First Minister; Rebecca Evans; Vaughan Gething; Kirsty Williams; Julie James; Lesley Griffiths; Ken Skates; Eluned Morgan; Jeremy Miles; Jane Hutt; Hannah Blythyn; Julie Morgan; Lee Waters; and Dafydd Elis Thomas.
**Local Government:** Cllr. Andrew Morgan – Chair WLGA.
**BAME COVID-19 Advisory Group:** Judge Ray Singh & Professor Emmanuel Ogbonna
**WCVA:** NR
**Opposition party leaders**: Paul Davies MS & Adam Price MS.
**Officials:** Permanent Secretary; Andrew Goodall; Chris Jones; Reg Kilpatrick; Albert Heaney; Jonathan Price; Carys Evans; Toby Mason; NR Chrishan Kamalan; Will Whiteley; Jo Trott; Christopher Morgan; NR Jonathan Scourfield.
**Special Advisers:** Jane Runeckles; Ian Butler; Sara Faye; Clare Jenkins; Gareth Williams; Tom Woodward.

**Public Health and NHS update**

1. The CMO reported that the 'R' rate of infection was somewhere between 0.6 and 1 in Wales, with an average at around 0.8. However, this was becoming a less accurate measure of infection with low transmission rates and there was a need to consider other factors, such as the occupancy of critical care beds.

2. The ONS was reporting around 3,000 new cases of COVID-19 a day in the UK, of which 150 were in Wales. The current rate of infection was reducing by a half in every thirty days, and rate of infection was also reducing in care settings, such as hospitals and care homes.

3. The CMO referred to the two recent outbreaks declared in Ynys Môn and Wrexham, which centred on meat and food processing plants, and noted that outbreak control teams were managing the cases. All cases directly linked to people working at these factories had been identified through the Test, Trace and Protect system.

4. There had also been an incident centred at a food plant in Merthyr Tydfil and investigations were continuing to establish whether transmission occurred at the site or within the wider community. It was recognised that the virus thrived in cold, damp and noisy environments and survived for longer indoors and particularly on smooth surfaces. Extensive guidance was being developed for the sector.

5. In terms of other matters, it was important to understand the equity implications and the direct and indirect harms of the pandemic. One specific issue was the significance of transparent PPE for people who support BSL users.

6. There was also a need to consider the long term rehabilitation of COVID-19 survivors, particularly in terms of pulmonary complications and mental health issues.

7. It was reported that the antibody and antigen tests, when used together were an effective surveillance tool, particularly in social care and schools settings.

8. In terms of the recent UK Government announcements in relation to England, the science behind the two metre safe distance rule as an effective barrier against the transmission of the virus was clear, but mitigations could be put in place where this was not possible. In addition, the outdoors was a safer environment for people to visit restaurants and cafes providing they did not congregate.

9. The Chief Executive of the NHS reported that the majority of Health Boards were continuing to report Green / level 1 as an indicator of capacity and response. Four hospital sites were reporting level 2.

10. There were 713 confirmed or suspected COVID-19 patients in NHS beds across Wales, which was the lowest it had been. There were 262 open and available critical care beds and around 130 were available for use. Of those occupied, 22 patients had COVID-19 related symptoms.

11. Cancer referrals were returning to normal and average attendance at Accident and Emergency Departments was beginning to rise. However, hospital admissions, outpatient appointments and GP attendance was still lower than normal. Some of this could be explained by digital consultations, which had been maintained to a high level. In addition, optometry and dental services had moved into the next phase of recovery. In the week ending 12 June, mortalities in Wales were now below the five-year average for the time of the year, which was considered to be an important milestone.

12. Hospital sites and settings were being adapted and modelling was being undertaken to prepare for further outbreaks in the Autumn and Winter months. It was likely that there would be a need for significantly more critical care beds than normal capacity provided, and the number of cases were expected to exceed those reported in April.

13. The Test, Trace and Protect programme had a positive impact, with many Local Authorities reporting few, and in some instances no, new cases of the virus. The drive in centre on Deeside was the busiest centre in Wales, with over 200 tests being carried out each day and more care home workers than NHS staff were being tested. Arrangements were in place to increase sampling.

**Local Government Update**

14. Cllr. Morgan reported that there were no significant issues across Local Authorities. It was noted that the Minister for Housing and Local Government would be speaking to the Leader of Ynys Môn Council later that day to discuss testing arrangements following the outbreak of the virus on the island. Results were being returned quickly and it was agreed that the data on testing for both outbreaks in North Wales would be shared with Ministers.

15. It was important to ensure that Local Authorities were given as much notice as possible as to when the Government intended to announce the re-opening of play areas as Councils would need time to make areas safe. Authorities would also welcome greater certainty about areas not expected to restart, such as theatres and leisure centres, as staff had been redeployed to the TTP programme.

16. Furthermore, authorities would need to continue to support vulnerable people beyond the shielding programme, which was due to end on 20th August. Authorities and the Third Sector may also continue to support individuals who had fallen outside of the shielding programme but for whom significant barriers remain, such as access to public or private transport.

**Contingencies / Resilience update**

17. The Director of Local Government advised the Group that the SCGs would be improving their lines of communications following the outbreaks of the virus at the food processing plants. There were a number of devolved and non- devolved public bodies and agencies, such as Local Authorities, the Health and Safety Executive, Food Standards Agency and Health Boards, involved and their responses would need to be co-ordinated. It was acknowledged that TTP had quickly identified the people that had been infected.

18. Investigations of the incident in Merthyr Tydfil were continuing, as it appeared that the 33 cases reported in the media had potentially occurred in workers at the site since April.

19. It was reported that Food Innovation Wales was undertaking a rapid review of the industry.

**Update from the BAME COVID-19 Advisory Group**

20. The First Minister welcomed Judge Ray Singh and Professor Emmanuel Ogbonna to the group and members were reminded that the BAME COVID-19 Advisory Group had been formed to consider the impact of COVID 19 on people from BAME backgrounds.

21. In addition to the work of Professor Singhal's group to develop a Self-Assessed Risk Assessment Tool a second sub-group headed by Professor Emmanuel Ogbonna, had been established to consider the socio-economic and social impacts of Covid-19 in BAME populations and the Professor was invited to summarise the group's recent report.

22. The sub-group included representation from BAME NHS and care workers, Public Health Wales, Health Boards and Trusts, the Equality and the Human Rights Commission Wales and Welsh Government. The group drew in expertise from: academia; third sector organisations; youth and community practitioners, with specialist knowledge of BAME mental health equality and human rights; education; gender inequality; housing; and social justice. The membership also included Trades Union officers.

23. There had been wide engagement across BAME community groups, with over 400 individuals taking part in a number of stakeholder meetings.

24. The sub-group had found that data on ethnicity across all health and social care services and many other public services was poor. The NHS Electronic Staff Record held ethnicity data on 85% of employees, but only 63% of medical and dental staff.

25. There was a considerable level of anxiety amongst employees about the risks of the virus and the potential additional risk for BAME workers as an at risk group. This had also exasperated mental health impacts. The self-assessment tool had been developed for all staff to avoid division and a suggestion that there was a hierarchy of importance. There was also a concern that people being identified as at risk would lose income as a result of being redeployed.

26. There were also communication issues, as important health and social care information had not been effectively disseminated to BAME communities. There was a need to support BAME grassroots groups that could disseminate key messages, such as the use of Vitamin D supplements.

27. In addition, health and social care was considered to be more difficult to access, with cultural and language barriers. The importance of interpreters and translation services was recognised.

28. BAME people were more likely to be employed in shutdown sectors, highlighting the need for security of employment and income. In addition, BAME people disproportionately suffered from housing overcrowding and this was also having an impact on young people who did not have the space or access to IT when undertaking school work.

29. There was the added financial burden of migration status, visa costs and health surcharges. In addition, the particular risks and barriers faced by the BAME community in accessing support to deal with violence against women, children, domestic abuse and sexual violence would need to be addressed.

30. There was structural and systemic inequality and disadvantage in health and social care outcomes arising from an embedded culture of racism in wider society. For example, in 2017, The National Centre for Social Research British Social Attitude Survey reported that 26% of a representative sample of British public described themselves as “very” or “a little” prejudiced against people of other races.

31. Similarly, the 2014 European Social Survey found that 18% of UK respondents believed that “some races or ethnic groups are born less intelligent” and 44% believed that “some races or ethnic groups are born harder working”. Unfortunately, such attitudes have become embedded in ways that disadvantage members of BAME communities in all aspects of life.

32. The recommendations within the report, particularly those that concerned racism in society, should serve as a necessary step to begin the process of addressing the concerns of BAME communities.

33. In addition to specific recommendations under each subject, an independent Racial Equality Champion for Wales should be appointed to drive structural and policy change in tackling race inequalities and systemic racism. A Race Disparity Unit should be established within Welsh Government, to place BAME issues at the heart of policy making by collating, analysing and publishing BAME data unique to Wales to assess progress on improving health and wider societal outcomes. In addition, a Race Equality Strategy for Wales should be produced.

34. The First Minister thanked Professor Ogbonna for his presentation and indicated that the Government would respond to the report in due course.

**Actions**

Officials to share the data on testing for both outbreaks in North Wales with Ministers. – Andrew Goodall / Jo-Anne Daniels

CABINET SECRETARIAT
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