THE WELSH GOVERNMENT'S MODULE 3 OPENING STATEMENT

1. The pandemic had far-reaching and continuing effects on healthcare services in Wales and the people of Wales. The Inquiry will hear powerful evidence about Covid-19 patients who were frightened and treated in busy and overstretched wards; from family members who were unable to be with their loved ones as they died; from NHS patients who struggled to access care and treatment for conditions other than Covid-19 and from those who continue to suffer from the pandemic's long-term effects. The Inquiry will also hear from frontline healthcare workers who, at great personal risk, continued to provide care and treatment to the people of Wales in the most challenging circumstances.

Healthcare in Wales

2. The overall provision of NHS services in Wales is the responsibility of the Welsh Government. Although the shorthand phrase "NHS Wales" is often used, there is no single legal entity for the NHS in Wales. NHS services are provided by health boards, trusts and special health authorities. Each health board is responsible for its area and NHS trusts and special health authorities are responsible for providing certain national services. Each NHS body is responsible for ensuring appropriate governance arrangements are in place to maintain the effective provision of health services which includes how, where and by whom services are provided. Operational decision-making rested with those NHS bodies who were responsible for day-to-day activities and the allocation of resources to ensure an efficient and effective service. [1]

3. The Welsh Government is responsible for funding the NHS in Wales. Before the pandemic, funding and investment had been constrained by the limits of austerity and the constantly growing demand for NHS services, therefore choices and priorities for funding were made within this context. Difficult decisions were required before and during the pandemic to determine allocation of the finite funding available. During the pandemic the Welsh Government provided additional funding to the NHS in Wales of £1.17B for revenue expenditure and £133M for capital purposes,[2] in the context of an annual expenditure for the NHS of £8.3B in 2020-21. Most, if not all, requests from health boards and NHS trusts for additional funding were granted.

Leadership of the NHS in Wales

4. The Welsh Government is also responsible for strategic decision-making, long-term planning and policy development. Welsh Ministers may direct NHS bodies to exercise functions in relation to the health service in Wales but operational responsibility for the provision of healthcare services rests with the individual NHS bodies.

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[1] M3-WGO-01, para. 130.
[2] M3-WGO-01, paras. 214- 217; M3-VGE-01, paras. 61-65.

5. Welsh Ministers issue strategic planning requirements in the NHS Planning Framework which reflects their health policy priorities. NHS bodies are required to plan in accordance with those priorities to meet the needs of those populations for whom they are responsible. The Welsh Government also publishes guidance to support policy requirements or to provide information about good practice.

6. The Welsh Government's long-term plan for health and social care in Wales was published in 2018. '*A Healthier Wales*' sought a balance between immediate healthcare pressures and the development of an effective healthcare system for the future. It recognised the importance of infrastructure outside of the hospital and the need to focus on community care, population health and health inequalities. The pandemic set back the progress of this plan.

7. Integrated Medium-Term Plans (**IMTPs**) are produced by all NHS bodies, based on the NHS Planning Framework to describe how those bodies intend to implement the priorities identified by the Welsh Government. IMTPs are approved by the Welsh Government which provides the funds for NHS bodies to implement them. During the pandemic, the Welsh Government recognised that NHS bodies required the ability to plan and respond more quickly and efficiently to developing circumstances. For that reason, the usual three-year IMTP planning cycle changed to weekly plans between March 2020 and May 2020 and thereafter to quarterly plans until March 2021. Annual plans were developed for 2021-22 and the requirements for 3-year IMTPs resumed for 2022-25.

8. In the uncertain times the Welsh Government faced, we and our stakeholders worked together within this system to respond to the emerging understanding of the virus. To support the quarterly planning cycle, the Welsh Government provided quarterly operating frameworks which set out (a) its priorities in response to the pandemic and (b) the harms to be considered in making decisions.[3] Increasing the frequency and agility of the NHS planning process allowed the Welsh Government and the NHS bodies to respond to the most up-to-date modelling provided by TAC/TAG and to learn from experiences. Where the Inquiry's evidence shows differences between health boards, that is a product of their statutory and governance responsibility for interpreting and delivering the priorities identified by the Welsh Government in the manner determined most suitable for their circumstances and population.

9. During the pandemic the Welsh healthcare system and healthcare workers were tested and pushed to limits never seen before. Whilst it is undoubtedly true that the experience exposed weaknesses in that system, it is also true that out of necessity was born innovation, cooperation and collaboration. The evidence also shows an inevitably complex picture where the national and

[3] M3-VGE-01, paras. 25 – 40.

local contexts are compared: for example, based on the available up-to-date information, the Welsh Government was confident that there were sufficient national stocks of appropriate PPE, but individual healthcare workers and NHS bodies reported difficulties obtaining the supplies they required.[4]

10. Before the pandemic the Welsh Government recognised that healthcare provision would benefit from a 'national executive' to speed up decision-making, to provide a shared planning approach at national, regional and local levels and, ultimately, to make the system more responsive to national priorities. The NHS Executive became operational in April 2023. On behalf of the Welsh Government, the NHS Executive supports the NHS in Wales to improve clinical services in line with the strategy, priorities and standards set by the Welsh Ministers. The experience of the pandemic – developing policy and interactive ways of working for example - has and will continue to inform the support and co-ordination that the NHS Executive will provide. [5]

11. The Welsh Government's experience during the pandemic influenced the development of an emergency preparedness function within the NHS Executive which built on the close working arrangements which had been put in place by the Covid-19 Health and Social Services Planning and Response Group. The Covid-19 Planning and Response arrangements brought together a number of national bodies and the NHS in Wales and this structure was transferred into the NHS Executive to retain and strengthen the strategic link between the Welsh Government and the NHS in Wales providing a national focus for coordination in the NHS in Wales emergency planning and contingency arrangements including monitoring and assurance of emergency preparedness.[6]

Core decision-making

12. <u>The suspension of non-urgent appointments and admissions:</u> On 13 March 2020, the Minister for Health and Social Services announced measures designed to enable NHS bodies and professionals to make timely preparations to address the anticipated increase in Covid-19 cases. [7] The measures included the suspension of routine appointments and the discharge of vulnerable patients in order to allow services and beds to be reallocated and for staff to be retrained in priority areas. The measures were developed following discussions with NHS Chief Executives. Listening to their concerns and the challenges they faced, the measures were designed to allow NHS bodies and professionals to make timely preparations to address the anticipated increase in Covid-19 cases,[8] in light of SAGE and COBR advice that the UK was just weeks away from a significant increase

[4] INQ000400723.
[5] M3-WGO-01, paras. 27-29.
[6] M3-WGO-03, para. 27.
[7] M3-VG-01, paras. 108-130; M3-AGO-01, para. 459
[8] M3-VG-01, paras. 108-130; M3-AGO-01, para. 459.

in Covid-19 cases. The Welsh Government published the measures and each individual NHS body responded by interpreting and applying them at a local level in a way which was most suitable for them.

13. Although the framework included a need to expedite the discharge of vulnerable patients from acute and community hospitals, and allowed for speedier placements to care homes by suspending the right to a choice of home, it did not affect the testing protocol then in place, which at that time was to test people with symptoms, with inpatient testing a priority, and priority given to ICU patients, followed by those with respiratory conditions and then key workers where capacity existed.

14. The Essential Services Group was responsible for the development, approval, production and dissemination of guidance. The list of essential services initially included primary care; urgent surgery (including access to urgent diagnostic and related rehabilitation); urgent cancer treatments (including access to urgent diagnostic and related rehabilitation); life-saving medical services (including access to urgent diagnostic and related rehabilitation); life-saving or life-impacting paediatric services and mental health services. Paediatric specialist services, cardiac and stroke services and hip fracture surgery were later added.[9]

15. The Inquiry's experts, Professor Andrew Metcalfe and Ms Chloe Scott, concluded that the de-prioritisation of elective surgeries was reasonable as an initial response but they criticise what they describe as a slow and inconsistent restart of those services. They considered that to be particularly pronounced in Scotland, Wales and Northern Ireland.[10]

16. From April 2020 onwards the Welsh Government communicated to the public the ongoing availability of essential and urgent services. [11] The Welsh Government published guidance about the extent to which the delivery of routine services could be resumed in each of the quarterly operating frameworks described above. How that translated into NHS organisations' plans was a matter for local decision, based on an assessment of what could be done safely and without compromising the system's ability to treat Covid-19 patients and to provide essential services. In June 2020, the Nosocomial Transmission Group published a "Principles Framework" to help the NHS to return to urgent and planned services in hospitals.[12] In March 2021, the Welsh Government introduced an NHS recovery plan. The Welsh Government was understandably cautious about the IPC risks of re-introducing services and increasing the number of patients in

[9] M3-WGO-01, paras. 645-673.
[10] INQ000474262.
[11] INQ000486014.
[12] INQ000299363.

hospitals and this approach reflected Welsh Government's approach to public health throughout the pandemic, in recognition of the demographic, infrastructure and capacity within Wales.

17. The Welsh Government worked with the All-Wales Cancer Network to assess the likely impact of the pandemic on cancer care. In April 2020, national guidance was developed for cancer services to inform prioritisation and access to treatment. [13] The Welsh Government, by letters from Dr Andrew Goodall and operating frameworks, emphasised the need to continue urgent and emergency cancer tests and cancer services in line with that national guidance.[14]

18. To support the reinstatement of cancer services, the Welsh Government endorsed the All-Wales Cancer Network's *"A Framework for the Reinstatement of Cancer Services in Wales during Covid-19"* [15] which was published in June 2020 and provided recommendations on how to continue to provide cancer care, to re-start certain aspects of treatment (such as complex surgery), and how best to protect patients awaiting treatment.

19. Professor Aneel Bhangu and Dr Dmitri Nepogodiev concluded that patients' uptake in the Welsh bowel-screening programme has declined slightly compared to pre-pandemic figures. The number of Welsh patients presenting electively for T2-4 stage cancer remained stable: between April and June 2020, 64% of expected colo-rectal operations happened but between April 2020 and March 2021 it had increased to 89%.[16] That evidence may indicate some measure of success in relation to cancer services.

20. Visiting restrictions: Guidance on facilitating hospital visits during the pandemic was issued by the Chief Nursing Officer in the form of letters to all NHS Wales Nurse Directors on 25 March 2020 and 20 April 2020. It took regard of the approach developed in other parts of the UK. The decision to restrict visiting was not taken lightly and the Welsh Government, in particular the Chief Nursing Officer, was acutely aware that they would be restricting the access of family and friends to their loved ones who were in-patients and of the affect that this would have on those accessing maternity services. However, reducing the risk of spreading the infection to other patients, staff, and members of the visiting public, a situation that carried the real potential to cause significant harm, had to take precedence.

21. The Inquiry will note the conclusion of Dr Shin, Professor Gould and Dr Warne that visiting restrictions played an important role in preventing the spread of infections within hospitals.

[13] INQ000399069.
[14] M3-WGO-01, paras. 663-673.
[15] INQ00035346.
[16] INQ000474244.

Although the question was difficult and no response could satisfy all stakeholders, we believe that overall an appropriate balance was struck between mitigating the risk of the virus spreading and allowing patients to see family and friends.

22. The Chief Nursing Officer's letters and guidance made it clear that enabling people to say goodbye to loved ones at the end of their lives was to be facilitated wherever possible, and appropriate personal protective equipment should be provided for visitors to ensure their safety.

23. Healthcare inequalities: The Welsh Government has always been committed to a more equal Wales and before the pandemic it consistently sought to take account of the needs of Black, Asian and Minority Ethnic citizens and disabled people in its decision-making. To that end, fora such as the Race Equality Form and Disability Equality Forum were long established, and from 2019 the Welsh Government had appointed two Specialist Policy Advisers in equality to support Ministers and policy-makers. The principle of planning and providing services at a local level is intended to allow those services to be tailored to the specific needs of the local population; to balance population health with the responsibility for service delivery. Notwithstanding those efforts the Welsh Government recognises that pre-existing health inequalities within Wales were exacerbated during the pandemic; that there were those who struggled to access the care that they needed and that the use of PPE, visitor restrictions and the increased use of virtual communications caused communication difficulties for those who were blind and/or D/deaf.

24. The Welsh Government has a well-established process in which equality impact assessments inform policy-making. However, it is accepted that in the early days of the response to the pandemic and because of the fast pace at which decisions had to be made, formal equality impact assessments were not carried out or published in the usual way.[17]

25. To ensure that decisions were informed and in the best interests of the most vulnerable and the most affected in Wales, the Welsh Government established the Black, Asian and Minority Ethnic Covid-19 Advisory Group and the Covid-19 Moral and Ethical Advisory Group for Wales to advise Ministers. The Welsh Government also continued to engage with established groups such as the Disability Equality Forum; the Race Equality Forum; the Faith Communities Forum; the Third Sector Partnership Council and the Refugee and Asylum Seeker Taskforce. The Disability Equality Forum commissioned the 'Locked Out, Liberating disabled people's lives and rights in Wales beyond Covid-19' report, published on 2 July 2021,[18] which made a number of recommendations relating to the healthcare system. As a result, the Disability Rights Taskforce

[17] M3-VGO-01, paras. 146-156.
[18] INQ000227530.

was established to bring together people with lived experience, Welsh Government policy leads and representative organisations to identify the issues and barriers that affect the lives of many disabled people.

26. The risk assessment sub-group of the Covid-19 Black Asian and Minority Ethnic Advisory Group for Wales developed a risk assessment tool that provided a means of allowing health and social care staff to identify the risk they faced from the virus. It was designed to be suitable for use for all health and social care staff and regardless of ethnicity. As reliable data regarding the nature and impact of the virus started to emerge, the Welsh Government's understanding of the impact on inequalities also developed. The Welsh Government acknowledges that there is further work to do as regards the collection of quality equality data and our Equality, Race and Disability Evidence Units are undertaking a detailed audit of equalities data across all topic areas to address this.

27. In June 2020, the socio-economic sub-group of the Covid-19 Black Asian and Minority Ethnic Advisory Group for Wales produced a report highlighting the disproportionate impact of the pandemic on minority ethnic communities. The report made 37 recommendations some of which concerned the healthcare sector. The Welsh Government published a detailed response to the report which confirmed its implementation of the recommendations, that action in relation to many was already underway, had been completed or commitment had been made to take further work forward. The recommendations formed an integral part of the Welsh Government's Anti-Racist Wales Action Plan.[19]

28. Child and Adolescent Mental Health Services: The Welsh Government accepts the conclusion of Dr Guy Northover and Dr Sacha Evans that the preparedness and response capabilities of the UK's healthcare systems failed to fully consider mental health illness and that failure necessarily affected the pandemic response and the delivery of CAMHS, particularly in the early stages of the pandemic.[20]

29. The Welsh Government responded swiftly and early in its response to the pandemic. In Wales, CAMHS services (both primary mental health services and specialist CAMHS) were 'essential services' during the pandemic and a range of measures were put in place to support them, including additional investment, expanding support for low level mental health issues, and providing additional surge capacity. This was emphasised in the Welsh Government guidance, its

[19] M3-VGO-01, paras. 157-164.
[20] INQ000474300.

operating frameworks and public communications. Overall, services remained open and accessible throughout the pandemic but with adapted service models.

30. A Mental Health Incident Group was convened which included the Welsh Health Specialised Services Committee, the National Collaborative Commissioning Unit (Mental Health) and Health Inspectorate Wales. As part of the Mental Health Incident Group, a monitoring tool was developed to provide situation reports on capacity of mental health services. This showed data provided by individual health board mental health and CAMHS services.

31. Dr Northover and Dr Evans concluded that in Wales there was a significant decrease in the number of face-to-face assessments conducted by staff from in-patient units before a young person was admitted to a mental health unit. It is right that CAMHS services were amongst the earliest in which the Welsh Government moved to promote and enable video and remote consultations, to maintain access to services where face-to-face assessments were not considered to be safe. The Welsh Government had a lead clinician within Aneurin Bevan Health Board to lead on this initiative and its success became a template for other services.

32. The Essential Services Group produced a CAMHS Assurance Review paper which concluded that the Welsh Government should take effective steps to support CAMHS in-patient services and to ensure sufficient bed capacity. Those steps included providing surge in-patient capacity and strengthening arrangements for patient flow; temporary modifications to the Mental Health Act 1983 and demand and capacity planning through the National Collaborative Commissioning Unit NHS Benchmarking toolkit for mental health and learning disability services.[21] Aware of the need for greater focus on mental health, the then First Minister created a new cabinet post of Minister for Mental Health, Wellbeing and the Welsh Language in October 2020.

Capacity

33. Critical Care capacity: The funding and availability of critical care capacity is a complex question. As noted by Professor Summers and Dr Suntharalingam, the UK as a whole entered the pandemic with a deficiency of critical care capacity[22]. Over the years the acute bed capacity in Wales has been reduced as new technology and clinical practice has changed.

34. In August 2017, the Critical Illness Implementation Group, which oversaw the Welsh Government's delivery plan for the critically ill concluded that critical care services in Wales were improving but that improvements were needed in areas such as delayed transfers of care and

[21] INQ000271699.
[22] INQ000474255.

critical care capacity. To address these issues, the Welsh Government established a nationally directed programme for critical care in 2018 which included £15M additional funding for critical care services in Wales from 2019-20, plus £5M in 2018/2019 to strengthen all aspects of critical care and help redesign the way critical care services in Wales are delivered. The Welsh Government did not, however, foresee or anticipate the need to respond to a pandemic situation of the level and consequence of the Covid-19 pandemic.

35. On 6 April 2020, the Minister for Health and Social Services set out the measures that were taken swiftly to increase critical care capacity: [23]
    a. Training had been provided to upskill hundreds of staff who did not normally work in critical care and extra areas had been identified in hospitals to provide more invasive ventilation to patients in addition to existing critical care units and surge capacity areas.
    b. The National Institute for Health and Care Excellence (**NICE**) published its Covid-19 rapid guideline for critical care in adults to maximise the safety of patients, protecting staff and making the best use of NHS resources.
    c. The number of critical care beds was normally around 153 but as of 3 April 2020 there were 353 critical care or invasively ventilated beds, a total which increased daily. Occupancy at that time was 48%, with just over half of occupants having confirmed Covid-19.

36. In June 2020 the Senedd's Health, Social Care and Sport Committee published a report which considered the first wave of the pandemic. Notwithstanding the significant and swift increase in capacity, the committee concluded that the critical care system, and overall bed complement, should not be run so 'hot' in the future. There was a need to ensure that there continued to be additional capacity, in terms of staffing, beds and equipment. Whilst investment began before the pandemic, as noted above ongoing investment is balanced with competing priorities for finite funding.

37. Although bed capacity limits were never breached in Wales, in certain hospitals there were times when capacity was so stretched that CRITCON level 3 was declared and, on one occasion, they were close to declaring CRITCON 4 because all capacity had been exhausted. On those occasions there was still limited capacity in neighboring health boards and the system of mutual support allowed demand to be satisfied. The Welsh Government was not made aware of any incidents where a patient who was clinically appropriate to receive critical care was unable to access a critical care bed in the relevant health board area or from a neighboring health board.

[23] M3-WGO-01, para. 382.

38. Field Hospitals: The establishment and use of field hospitals was an essential facet of the Welsh Government's plan to increase available capacity. Based on early modelling, it was recognised in March 2020 it was essential to quickly increase capacity in the NHS in Wales,[24] to take and be seen to take whatever steps were required to keep people safe and ensure enough beds were available. Once field hospitals were built and funded, the operational decisions about their use lay with health boards which were best placed to identify and manage the demands on their capacity. The Welsh Government continually reviewed the need for field hospitals, their size and funding to make sure that they were an appropriate use of public funds. If they were no longer required, they were reduced or closed.

39. As the pandemic developed field hospitals were used differently than first anticipated. In the first wave the Welsh Government established field hospitals because it anticipated having to deal with a reasonable worst-case scenario with capacity needed for end-of-life care. That this capacity was not ultimately required was a result of the success of the non-pharmaceutical interventions including lockdown, which at the time could not be guaranteed. Ultimately, the use of field hospitals in the 'step-down' model of care – with acute care delivered in existing hospital sites and field hospitals protecting capacity and flow by supporting patients recovering from Covid-19 who weren't yet ready to return home – alleviated pressures on NHS hospitals when it was required. If those patients who were treated in or utilising field hospitals had been forced to stay in hospital that would have affected them individually and had an effect across the wider system.

40. Private hospitals: Wales usually has significantly less capacity relative to England. Commissioning from the independent sector was another important means of increasing capacity available in Wales. Approximately £58.1M of additional funding was provided by the Welsh Government to commission capacity in the private sector and systems were put in place to ensure that the contracts were managed to provide value for money. As above, the need to increase capacity was anticipatory and based upon the modelling and advice at the time.

41. Once the Welsh Government funded, and the Welsh Health Specialised Services Committee secured, the private capacity, it was for health boards to decide how that capacity would be used based on local needs. Although private hospitals were not used to treat patients with Covid-19, they were used to provide additional outpatient, diagnostic and inpatient capacity for non-Covid-19 care. The Welsh Government recognised early on that additional capacity would be

[24] M3-VG-01, paras. 221-246.

required and utilising private hospitals was a means of keeping non-Covid-19 healthcare available.

Preventing the spread of Covid-19 in healthcare settings

42. The Welsh Government accepts that, despite the focus on IPC in Wales, there were too many hospital-acquired infections. For that reason, it has funded a comprehensive national programme of work to investigate and learn from more than 18,300 cases of healthcare-acquired Covid-19 infections.[25] The programme's final report was published in August 2024.

43. The statistics cited by Dr Shin, Prof Gould and Dr Warne show that Wales had a significantly higher percentage of hospital onset cases of Covid-19 during the first wave of the pandemic than England and Scotland. Analysis from national surveillance data in Wales identified that, adjusting for confounding factors, there was no increased mortality for hospital-acquired cases compared to cases admitted with Covid-19 from the community. It is not known whether the lower level in England reflected differences in hospital admissions or testing over those peak months.

44. IPC Guidance: Health and social care providers in Wales were asked to adhere to the UK IPC guidance. The guidance was based on a continuous review of the international evidence base and was issued jointly by the DHSC, Public Health Wales, the Public Health Agency in Northern Ireland, Public Health Scotland, the UK Health Security Agency and NHS England – also referred to as the 'UK IPC Cell'. Save for the question of mandatory face coverings in indoor public spaces,[26] there was a four-nation approach to IPC guidance.

45. In May 2020, the Welsh Government established the Nosocomial Transmission Group (**NTG**) which was chaired by the Deputy Chief Medical Officer and the Chief Nursing Officer. Its membership was drawn from the Welsh Government, Public Health Wales and representatives from the health, social care and professional organisations. The NTG provided advice, guidance and leadership for all healthcare settings including hospitals, primary and community care and its aim was to minimise nosocomial transmission and to enable the safe resumption of services.

46. The NTG worked with stakeholders to develop a wide range of guidance and resources, including on the practical implementation of UK IPC Cell guidance; cleaning standards; bed-spacing; social and physical distancing; the use of screens and barriers; ventilation; environmental controls; testing; PPE; IPC training and learning and development.

[25] M3-WGO-01, paras. 280 -282.
[26] M3-CMO-01, paras. 27-34.

47. The Inquiry will note that Dr Gee Yen Shin, Professor Dinah Gould and Dr Ben Warne concluded that the utility of guidelines to support suitable IPC practice was limited by the extent to which they were translated into practice. That, in turn, depended on factors, including the trust that health professionals have in the published guidance, the available time and resources to apply the guidance and the quality of that guidance.[27] The regular introduction, development and amendment of guidelines was necessary to meet the developing understanding of a novel virus. The Welsh Government recognises that this caused confusion and mistrust and anxiety in health professionals, and difficulties in operational implementation for NHS bodies.[28]

48. Testing was a key part of minimising nosocomial transmission. The Welsh Government published updated testing plans and strategies throughout the pandemic, based on the best evidence and available testing capacity at the time. The policy of testing health and social care staff was monitored through discussions in Testing Clinical Advice and Prioritisation Group.[29] The Welsh testing programme developed during the pandemic. Throughout Public Health Wales gave advice and guidance about who should be tested and when. As part of that work, Public Health Wales liaised with the Chief Medical Officer's office.

49. It was difficult to balance the availability of tests, the modelling data and the relative risks of the options involved. The Welsh Government accepts that it was not until December 2020, and with the benefit of the validation and availability of lateral flow devices, that the routine testing of asymptomatic healthcare workers was introduced with a programme of twice-weekly testing of patient-facing health and social care workers.

50. The NTG monitored nosocomial incidents and outbreaks and the effectiveness of health board responses by the use of a daily reporting tool. This also enabled the NTG to identify and share good practice on outbreak management. The Welsh Government's Internal Audit Service undertook a review of the NTG in September 2021 and it provided assurance in relation to its provision of guidance and the mechanisms in place to ensure effective implementation of that guidance.[30]

51. Throughout the pandemic the Welsh Government was aware of the challenges to infection prevention and control posed by an ageing hospital estate, particularly in relation to ventilation and isolation capacity. Before the pandemic the NHS in Wales, in commissioning new hospitals, had used those new builds to create safer environments including a greater focus on single rooms.

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[27] INQ000474282.
[28] INQ000475209.
[29] M3-CNOW-01, paras. 269-271.
[30] INQ000022598.

However, as Dr Shin, Professor Gould and Dr Warne noted in their report, there were (and remain) no quick fixes to the problem of the existing NHS estate because the cost of the necessary improvements may be prohibitive. Guidance and tools were provided to support health boards in mitigating and addressing the challenges during the pandemic. Health boards in turn interpreted and applied those in line with their operational response and local circumstances.

52. In November 2020, the NTG briefed the Minister for Health and Social Services that a substantial and frequently cited cause of the nosocomial spread of Covid-19 had been the inability to achieve adequate isolation for patients with confirmed or suspected infection due to a lack of single occupancy rooms. The NTG also noted that the required 3.6m distance between beds had not been (and could not be) fully implemented across Wales because of the number of beds that would have to be removed. The Welsh Government's actions to increase capacity (including the use of field hospitals and the accelerated opening of the Grange Hospital) were essential steps to mitigating the problem of an insufficient number of isolation rooms.[31]

53. PPE: The provision of appropriate and high-quality PPE was undoubtedly one of the most significant challenges in ensuring the safety and wellbeing of the health care workforce.

54. The Welsh Government managed and monitored PPE stocks first through the Covid-19 Health Countermeasures Group and later through the PPE Cell, which was tasked to undertake three things: first, to review the sourcing of PPE for Wales; secondly, to consider the stockpiling of PPE and, thirdly, to assess the arrangements for the distribution of PPE across Wales for both the health and social care sectors. Formal reporting of PPE stockpiles and usage started on 9 March 2020.

55. Although the procurement of PPE was conducted at a national Welsh level, requests for PPE products by NHS bodies in Wales (including hospital and ambulance services) followed the normal procurement requisitioning process utilising the NWSSP oracle system. Therefore, although at a national level there were always sufficient stocks of PPE in Wales, getting stockpiles to appropriate levels for individual NHS bodies was a pressing concern and that inevitably created anxiety for staff.

56. In July 2020, the Senedd published a report into the impact of the pandemic and its management on health and social care in Wales.[32] It reported the findings of surveys of the British Medical Association, the Royal College of Nursing and the Royal College of General Practitioners. A

[31] INQ000396261.
[32] INQ000349686.

significant proportion of the healthcare staff registered with those organisations reported concerns about the availability of adequate PPE in the first wave and those concerns are reflected in the evidence before the Inquiry.

57. 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. The NHS Shared Services Partnership, with assistance from the Armed Forces, established a distribution network far larger than anything anticipated or operating before the pandemic. The supply of PPE in Wales moved from a routine supply from discrete distribution centres to accessing hundreds of NHS and social care facilities. Notwithstanding this, the evidence from those on the front line of the NHS shows that there were still instances where individuals or individual hospitals struggled to obtain sufficient and/or suitable PPE.

Shielding and the impact on the clinically vulnerable and the clinically extremely vulnerable

58. There were some within Wales who were recognised as being clinically vulnerable or clinically extremely vulnerable to severe complications of Covid-19. Those individuals were asked to endure the most stringent restrictions on their lives in an effort to keep them safe. The shielding programme was introduced in Wales on 16 March 2020 and continued in differing forms until 31 March 2022.

59. The Welsh Government recognises that there were shortcomings in the process by which clinically vulnerable and clinically extremely vulnerable individuals were identified. In particular, no formal equality impact assessment was carried out before the policy was introduced. The policy and its development would also have benefited from greater direct consultation with disabled people, an omission that was rectified through engagement with Disability Wales from June 2020 onwards. The Welsh Government also accepts the conclusions of the Senedd Committee that there was not always clear communication with those being asked to shield and their families.

60. However, the Welsh Government's *"Impact of shielding on vulnerable individuals: integrated impact assessment"* noted that the most significant impact of the shielding policy was positive, with the creation of a robust system of governance that provided assurance that access to services and provisions continued for those who were identified as extremely vulnerable/shielding.[33]

[33] INQ000066205.

61. In May 2020, when the UK Government relaxed restrictions and discontinued shielding during the summer months, on the basis of the evidence relating to the particular circumstances in Wales and with the benefit of advice from the Chief Medical Officer for Wales and the views of the Disability Equality Forum, the Minister for Health and Social Services decided to continue shielding until 16 August 2020. Although that decision caused distress to some, and there was some confusion caused by the different guidance in England and in Wales, the decision was made to protect the clinically vulnerable and clinically extremely vulnerable in Wales.

Long Covid

62. The Welsh Government recognised in Spring 2020 that there would be a need for rehabilitation services for people who had been significantly affected by Covid-19 infection. The programmes and services developed to respond to that need have been informed by the developing understanding of Long Covid. The Welsh Government's approach has been guided by the principle that rehabilitation services should be delivered at local level through existing primary and community care services. Although the Welsh Government does not directly commission these services, it works closely with health boards who provide them and it issued the "*All-Wales Community Pathway for Long Covid*" to inform and underpin their delivery. That framework was developed in collaboration with health board Directors of Therapies and Health Sciences, Assistant Medical Directors and others. Since June 2021, the Adferiad (Recovery) programme has focused on providing assessment, diagnostic, treatment and rehabilitation support through existing primary and community care structures, with referral to more specialised services for those who required it. The funding provided by the Welsh Government has enabled such support to be further developed and expanded to meet patient needs, including the development of digital guidance and resources on managing Long Covid.

Conclusion

63. The Welsh Government was committed, throughout the pandemic, to protecting the Welsh population and saving lives. The Welsh Government's response is a product of the system within which it operates. We worked in partnership with stakeholders, frontline workers and the public to assist the NHS in Wales to respond to the extreme challenges it faced; to protect it from being overwhelmed, to increase capacity should the worst-case scenario materialise and to minimise transmission. The Welsh Government supports the need for this Inquiry to identify lessons that can be learned and improvements that could be made to improve its healthcare response in the event of any future pandemic.

Dated 23 August 2024