Witness Name: Andrew Goodall

Statement No.: 1 M3/WGO/01

Exhibits: 341

Dated: 10 May 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ANDREW GOODALL

Contents

I, Andrew Goodall will say as follows: -

1. I provide this statement in response to a request made by the Chair of the UK Covid-19 Public Inquiry ("the Inquiry") under Rule 9 of the Inquiry Rules 2006 addressed to the Welsh Government Health and Social Services Group ("Health and Social Services Group") referenced M3-WGO-01.

Preface

2. The purpose of this statement is to assist the Inquiry to investigate and analyse the healthcare decisions made during the pandemic, the reasons for them and their impact, so that lessons can be learned, and recommendations made for the future.

3. The pandemic had an unprecedented impact on health systems across the UK. In Wales our day-to-day activities and ways of working were affected, our local communities were impacted by the many decisions necessary to keep Wales safe and the NHS in Wales, as overseen by the Welsh Government, was inevitably disrupted by these extraordinary events.

4. This was an unprecedented period for us all, not just as members of the Welsh Government, the civil service and the NHS but also as individuals. We all lived through this experience professionally and personally and there were impacts and consequences for family, friends, colleagues and our communities. I wish to personally express my sympathies to those affected and to all those who lost loved ones during the pandemic.

5. I am grateful to colleagues in the Welsh Government Health and Social Services Group for their contribution and support in delivering Welsh Government's functions and responsibilities. I would also wish to recognise the exceptional efforts and commitment of health and social care workers across Wales who underpinned our response throughout the course of the pandemic response, and who continue to deliver these services for the people of Wales.

6. My response to the Inquiry's request for evidence made under rule 9 of the Inquiry Rules 2006, referenced M3-WGO-01, will cover the period from 1 March 2020 to 28 June 2022 (which I will refer to in this statement as "the pandemic period").

7. In order to fully address the Inquiry's request for evidence on the matters outlined this statement I have needed to obtain information from senior members of the civil service in order to cover the full breadth and depth of the request. I have identified these individuals in the statement at the relevant points.

Professional background and experience

8. I have a law degree from Essex University and a PhD in Health Service Management from Cardiff Business School, Cardiff University.

9. I was appointed to the role of the Welsh Government's Permanent Secretary in September 2021 and took up the role in November 2021. I lead the Welsh Government Civil Service in delivering the priorities of the First Minister and his ministerial team. I am the Welsh Government's Principal Accounting Officer and principal advisor to the First Minister and Cabinet. I should emphasise this is a unified and integrated Government, rather than a department. Accordingly, I am responsible for organising civil service support to ministers across a wide range of policy, legislative and administrative areas. An equivalent range of responsibilities would be discharged by several Permanent Secretaries at UK Government level.

10. Prior to this, I was the Director General of Health and Social Services and Chief Executive NHS Wales, a position that I had held since June 2014.

11. Before being appointed as the Director General, I was the Chief Executive of Aneurin Bevan University Health Board, a position that I held from the Health Board's inception in October 2009 until 2014.

Broad overview and reflections on the Health and Social Services Group and NHS Wales activities during the pandemic period

12. During the course of the pandemic, I wrote four Accountable Officer letters to the Welsh Government's Permanent Secretary which set out what I saw as the key factors at the time which shaped and informed the Welsh Government's response. They were intended to act as a contemporaneous record and to allow for personal reflections and

changes to take place; I also deliberately retained the format for consistency at the different phases to help track the environment and our response. These four letters are set out in exhibits **AGM3WGO01/01 - INQ000182427, AGM3WGO01/02 - INQ000227296, AGM3WGO01/03 - INQ000083233** and **AGM3WGO01/04 - INQ000083234.**

13. When I took up my current role of Permanent Secretary in November 2021, my successor to the Director General Health and Social Services role, Judith Paget, continued with the practice of chronicling and documenting the Health and Social Services Group's response to the Covid-19 pandemic. Judith's letter is exhibited at **AGM3WGO01/05 - INQ000083235.**

14. My four letters summarise the work undertaken by the Health and Social Services Group throughout the phases of the pandemic, much of which is set out in this statement, and reflect my assessment of that work at the time of writing. Some of my personal reflections include:

    a) The dedication and leadership of the Chief Medical Officer, Chief Scientific Advisor, Chief Nursing Officer and the wider Health and Social Services Group Executive Director Team was outstanding.

    b) The Covid-19 Planning and Response Cell (which I detail later in the statement) was able to draw resources from across the Health and Social Services Group, and the ability to gather our organisations and leaders together regularly and urgently and the use of existing system accountabilities and oversight was an advantage in Wales, though there had been times when this was more difficult due to the fast pace of system and ministerial decisions, and sometimes the more limited nature of our national resources placed a lot of focus on specific individuals and their roles to deliver.

    c) The Ministerial actions announced on 13 March 2020 set the tone for the NHS Wales to move to a visible and different phase of preparation and was a clear statement of intent for system preparation, at that time ahead of other parts of the UK. This early action proved to be crucial in ensuring that NHS and social care services were not overwhelmed in the weeks that followed.

d) Twice weekly national conference calls with NHS Chief Executives and weekly meetings with Chairs and Chief Executives attended by the Minister and Deputy Minister facilitated regular touch points and enabled co-ordination and mobilisation of actions, the identification and mitigation of risks and regular and ongoing engagement and support.

e) Military Liaison Officers deployed to the seven local health boards brought expertise and knowledge across a range of areas and were an invaluable asset.

f) I wished we could have better described the potential for increasing testing activity and capacity early on in the pandemic because some of our initial intentions and assumptions could not be achieved in the fast-moving environment and changing international market. We were also concerned that public discussion became focused on testing targets and not on the fundamental purpose of testing. The scale of testing needs and its profile meant that at times we had less central resources available as I would have had wished and were particularly reliant on advice and support from our internal professional advisors and Public Health Wales, a role beyond its core role.

g) Restoring NHS activity to near normal levels and work to address waiting lists will take several years and the need for additional funding. Recovery will need to be agile and ambitious, with the need for radical solutions. It will also need to 'build back fairer', given direct and indirect harms were more likely to affective vulnerable groups, people from minority ethnic communities and people from deprived communities.

h) Relations with the UK were, as of the 29 September 2020 letter, positive but required constant attention as there was a tendency for the partnership to be less than equal. This remained a challenge at the time of the fourth letter in October 2021. For example, Wales benefitted greatly from working at a UK level with the National Testing Programme, and devolved governments had become more involved and able to opt out of elements of the National Testing Programme which didn't support our strategy and testing purposes. However, it was an ongoing challenge to ensure that governance arrangements recognised the equal status of each of the four nations, and with the establishment of the UK Health and Security

Agency there was a concern that the forum in which UK Government engaged with devolved nations was an adjunct to the main decision-making mechanisms.

i) I was immensely proud of the dedication and resilience shown by members of the Health and Social Services Group but concerned about the strain placed on certain teams and individuals.

j) The Technical Advisory Group modelling data for the Christmas 2020 period and the second wave proved to be fundamental in informing timely decision making to prevent the system from becoming overwhelmed.

k) NHS staff have been outstanding in their response and for the protection they have afforded to the Welsh population. We will need to track NHS staff wellbeing for some years to come and many will need to come to terms with the impact of their personal and professional experience through the pandemic.

l) A small and limited team did remarkably well to oversee the Test, Trace, Protect process from its establishment, thought it was at times very stretched.

m) The Technical Advisory Cell's work helped to inform the steady, cautious approach adopted by the Health and Social Services Group and the Welsh Government throughout the third wave, and the provision of advice on such a broad range of issues would not have been possible without the Technical Advisory Cell's collaborative approach to science through its expert panel.

n) In the final letter dated 29 October 2021, I noted that I and my team of Directors continued to reflect on the Health and Social Services Group's emergency planning arrangements in light of the Covid-19 experience and that, while we were fortunate to have had our pandemic plans and emergency response arrangements, my successor would want to consider how to build on these for the longer term.

15. All of these reflections above are in my mind when preparing this statement for Module 3 of the Covid-19 Inquiry which captures the significant work undertaken by those within and supporting the healthcare system in Wales.

Legislative Background to Health Services in Wales

16. Healthcare has been a devolved function since 1999[1]. The NHS in Wales is therefore the responsibility of the Welsh Government. The Welsh Ministers set the high level policy framework and targets for the health service, which are then delivered by local health boards and NHS trusts in Wales. The full legislative history of the devolution of health in Wales is outside the scope of this Inquiry and statement but the governance and structures of the NHS in Wales may be traced back to the National Health Service Act 1977. Exhibit **AGM3WGO01/06 - INQ000274845**[2] sets out a detailed description of the legislative framework for the NHS in Wales, the key relevant information from which I describe here.

17. While the term "NHS Wales" is commonly used to refer collectively to local health boards, trusts and special health authorities in Wales, unlike NHS England, there is no central legal entity of this name. NHS Wales is shorthand for "the NHS in Wales" and collectively refers to local health boards, trusts and special health authorities in Wales ("NHS bodies in Wales") and those carrying out NHS functions on their behalf, to provide a range of primary, secondary, and specialist tertiary care services and community services including district nurses, health visitors, midwives, community-based speech therapists, physiotherapists and occupational therapists.

18. The Welsh Ministers (served by the Welsh Government's Health and Social Services Group) are responsible under the NHS (Wales) Act 2006 for the promotion and provision of a comprehensive health service in Wales which includes the provision of hospitals and other services or facilities as required for the diagnosis and treatment of illness. The Welsh Ministers have a broad range of powers that they may exercise in relation to the NHS bodies in Wales, this includes the power to direct local health boards, trusts, and special health authorities in relation to how they exercise their legal responsibilities under the NHS (Wales) Act 2006 or to perform legal responsibilities on the behalf of the Welsh Ministers. The Welsh Ministers have established local health boards which together cover the whole of Wales; and the Ministers have delegated various functions to each board established, in respect of its own area and particularly

[1] This function was initially carried out by the National Assembly for Wales until transferred to the Welsh Ministers in 2006.
[2] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000273962]

in respect of the usual residents in that area. Each local health board is legally responsible for healthcare service in relation to a particular part of Wales. NHS Trusts and special health authorities in Wales are also similarly established under the NHS (Wales) Act 2006 and are directed by the Welsh Ministers to provide specific services on an all-Wales basis. Further information on each of the local health boards, trusts and special health authorities and their legal responsibilities is provided below at paragraphs 80 to 95.

19. While delivery of health care services is the responsibility of the NHS bodies in Wales there are two important legal responsibilities which fall to the Welsh Minsters:

    a) Monitoring of the financial duties of NHS bodies in Wales – this is delivered via the NHS Wales Planning Framework (detailed below at paragraphs 73 to 75).

    b) Approval of plans and monitoring of performance - the NHS (Wales) Act 2006 requires each health board to submit plans to the Welsh Ministers setting out how they will use the funds allocated to improve the health of the people and the provision of health care to those people for whom it is responsible. These plans be approved by the Welsh Ministers. Additionally, powers under the NHS (Wales) Act 2006 enable the Welsh Ministers to intervene if an NHS body in Wales is not performing one of more of its functions adequately or at all, or where there are significant failings in the way the body is being run. This is formally monitored via the NHS Wales Planning Framework.

20. The Welsh Ministers receive policy advice from the Welsh Government's Health and Social Services Group which is led by a senior civil servant who holds the dual role of Director General Health and Social Services and Chief Executive of NHS Wales, the role I held prior to and for a significant part of the pandemic period. In practice, this dual role enables a very close working relationship between the Welsh Government and NHS Wales which is facilitated by the Chief Executive NHS Wales who in that role provides strategic leadership and management to NHS Wales.

Integration of Health and Social Care in Wales

21. While this statement will focus on the healthcare system in Wales, it is important to note that in Wales we have an integrated healthcare and social services system which

the Minister for Health and Social Services, supported by the Health and Social Services Group, oversees. The nature of the Welsh Government's oversight of social care is however fundamentally different to the healthcare system for which the Welsh Ministers are responsible for both the policy and ensuring the delivery of services by NHS bodies. In respect of social services and social care the Welsh Government leads on policy but not the delivery of services.

22. In 2018, 'A Healthier Wales', our long-term plan for health and social care ("the Plan") was published by the Welsh Government in response to the commitment under 'Prosperity for All', the Welsh Government's Programme for Government, to further integrate health and social care, building on the work and recommendations of the Parliamentary Review into Health and Social Care. A copy of the Plan is exhibited in **AGM3WGO01/07 - INQ000066130**. This complemented the provision in the Social Services and Well-being (Wales) Act 2014 ("the 2014 Act"), a key principle of which was the requirement for integrated and sustainable care and support services. The Plan refers to seamless health and social care promoted by and through Regional Partnership Boards ("RPBs")[3]. The 2014 Act had provided for the establishment of seven RPBs, on the health board footprint, which brought together health boards, social services, third sector and other partners. RPBs jointly assess, plan and provide efficient and effective services for their area with the purpose of improving the outcomes and well-being of people with care and support needs, and carers who need support.

23. The 2014 Act also seeks to ensure that a population assessment by RPBs is taken into account as part of broader integrated planning frameworks, for example, within Local Well-being Plans (required under the Well-being of Future Generations (Wales) Act 2015) and NHS Integrated Medium Term Plans[4]. Local authorities and health boards must jointly produce and publish a report of the outcome of their population assessments.

24. Legal responsibility for the delivery of social care in Wales therefore lies with the local authorities but throughout the pandemic period the Welsh Government and NHS worked closely with the social care sector to maintain an integrated response to the

[3] See exhibit AGM3WGO01/06- INQ000274845 for further information on RPBs
[4] See exhibit AGM3WGO01/06 - INQ000274845 for further information on IMTPs

pandemic. Health and Social Services Group officials engaged with local authorities to enable decisions to be made which considered health and social services together. Therefore, the separation and distinction of the "healthcare system" in this statement is to an extent an artificial one for the purposes of this statement.

Welsh Ministers, Special Advisers and Senior Civil Servants within or with oversight of the healthcare system in Wales

Minister for Health and Social Services

25. As noted above, the Welsh Ministers (served by the Welsh Government's Health and Social Services Group) are responsible under the NHS (Wales) Act 2006 for the promotion and provision of a comprehensive health service in Wales. This is led by the Minister for Health and Social Services. During a health emergency, the Minister for Health and Social Services is responsible for preparedness for the NHS and health sector, NHS initial capacity and ability to increase capacity and resilience.

26. The Minister for Health and Social Services is a Cabinet position in the Welsh Government. This position was held by the following people within the date range relevant to this Module:

    i. Vaughan Gething, MS, May 2016 to May 2021.

    ii. Eluned Morgan, MS, May 2021 for the period of this module and currently continues in this role which was renamed as Cabinet Secretary for Health and Social Care in March 2024.

27. Supporting the Minister for Health and Social Services is the Deputy Minister for Health and Social Services. Within the date range relevant to this Module, the role of Deputy Minister for Health and Social Services was held by Julie Morgan, MS.

28. Additionally, between the 13 October and 13 May 2021 a new ministerial post was created for a Minister for Mental Health, Wellbeing and the Welsh Language which was filled by Eluned Morgan, MS. From 13 May 2020 the role of Deputy Minister Minister for Health and Social Services was split and Julie Morgan, MS held the role of Deputy Minister for Social Services and Lynne Neagle, MS the role of Deputy Minister for Mental Health and Well-being.

29. A summary of the ministerial portfolios for the period covered by this Module is set out in exhibits **AGM3WGO01/08 - INQ000066139**, **AGM3WGO01/09 - INQ000066140**, and **AGM3WGO01/10 - INQ000066053.** The portfolios for the Minister for Health and Social Services and the Deputy Minister for Health and Social Services, whose portfolios are most relevant to the scope of Module 3, are set out below.

February 2020 to October 2020

30. For the period February 2020 to October 2020 the Minister for Health and Social Services portfolio held by Vaughan Gething MS covered:

- Oversight of NHS delivery and performance
- Delivery of new outcome measures
- Delivery Plans
- Scrutiny of NHS performance against three-year plans
- Oversight of escalation procedures
- Charges for NHS services
- Mental health services
- Receipt of, response to and direction of reports from HIW
- Oversight of the Welsh Government's relationship with the WAO regarding activities relating to the NHS
- Research and development in health and social care
- Medical workforce training and development with the exception of years 1-5 of University Education for Doctors
- All aspects of public health and health protection in Wales, including food safety and the fluoridation of drinking water
- The activities of the Food Standards Agency in Wales

- Genetically-modified food (but not the cultivation of genetically-modified crops)
- Responsibility for the Prison Service health service, other than private contracts
- Health impact of problem gambling
- Substance misuse
- Armed Forces and Veterans' Health
- Children's and young people's rights and entitlements, including the UN Convention on the Rights of the Child, the Children's Commissioner for Wales
- Early Years and Childcare
- Legislation relating to the removal of the defence of Reasonable Chastisement
- Flying Start Initiative for children 0-3
- Families First and play policies
- Adoption and fostering services in Wales
- Safeguarding
- Children and young people's advocacy, including complaints, representations and advocacy under the Social Services and Well-being (Wales) Act 2014
- Information sharing under the Children Act 2004
- Cafcass Cymru
- Policy and oversight of the provision of all social services activities of Local Authorities in Wales, including the issue of statutory guidance
- Policy on care in the community
- Oversight of Social Care Wales

- Regulation of residential, domiciliary, adult placements, foster care, under 8`s care provision and private healthcare in Wales

- Inspection of, and reporting on, the provision of social services by Local Authorities in Wales (via Care Inspectorate Wales), including joint reviews of social services and responding to reports

- Relationships with the Older Peoples' Commissioner for Wales

October 2020 to May 2021

31. Between February 2020 and October 2020 despite not being formally updated into the responsibilities, the Minister for Health and Social Services , was heavily in engaged in the pandemic response. From October 2020 to May 2021 the Minister for Health and Social Services' portfolio changed to include the following new responsibilities not listed above:

    - Public health: Covid-19 response, screening and vaccination

    - Health innovation and Digital

32. As outlined above, this position continued to be held by Vaughan Gething MS and a new ministerial post was also created from October 2020 to May 2021, the Minister for Mental Health, Wellbeing and the Welsh Language, which was held by Eluned Morgan MS. A number of the responsibilities which were those of the Minister for Health and Social Services during February to October 2020 were assigned to this new Ministerial portfolio. The health aspects of the portfolio were as follows:

    - Mental health services

    - Dementia

    - Autism

    - Health impact of problem gambling

    - Substance misuse

    - Armed Forces and Veterans' Health

- Health improvement and wellbeing services
- The activities of the Food Standards Agency in Wales, including food safety
- Genetically-modified food (but not the cultivation of genetically-modified crops)
- Obesity strategy
- Patient experience, involvement and the citizen's voice
- Research and development in health and social care

May 2021 to October 2021

33. From May 2021 to October 2021 the portfolio for the Minister of Health and Social Services returned to the fuller list of responsibilities which included metal health services. The post was held by Eluned Morgan MS. The full list of responsibilities were:

- Public health: Covid 19 response, screening and vaccination
- NHS delivery and performance
- Escalation procedures
- Receipt of, response to, and direction of reports from Health Inspectorate Wales
- Oversight of the Welsh Government's relationship with Audit Wales regarding activities relating to the NHS
- Medical workforce training and development [with the exception of years 1-5 of University Education for Doctors]
- Research and development in health and social care.
- Health innovation and Digital
- Mental health services
- Suicide prevention

- Dementia
- Autism
- Health impact of problem gambling
- Substance misuse
- Armed Forces and Veterans' Health
- Public Health: Health improvement and wellbeing services
- Obesity strategy
- Food Standards Agency in Wales, including food safety
- Genetically-modified food (but not genetically-modified crops)Patient experience, involvement and the citizen's voice
- Safeguarding
- Adoption and fostering services
- Children and young people's advocacy including complaints, representations and advocacy under the Social Services and Well-being (Wales) Act 2014
- Information sharing under the Children Act 2004 Cafcass Cymru
- Policy and oversight of the provision of all social service activities of Local Authorities in Wales, including the issue of statutory guidance
- Oversight of Social Care Wales
- Regulation of residential, domiciliary, adult placements, foster care, under 8's care provision and private healthcare
- Inspection of, and reporting on, the provision of social services by Local Authorities (via Care Inspectorate Wales), including joint reviews of social services and responding to reports

- Children's and young people's rights and entitlements, including the UN Convention on the Rights of the Child
- Early years, childcare and play, including the Childcare offer and workforce
- Early childhood education and care
- Flying Start for children 0-3
- Families First and play policies.

October 2021 to the end of the relevant period

34. From October 2021 to the end of the relevant period the portfolio for the Minister of Health and Social Services was unchanged in respect of the health responsibilities. This position continued to be held by Eluned Morgan MS to the end of the relevant period.

Special Advisers

35. Throughout the specified period, Clare Jenkins acted as Special Adviser to the Minister for Health and Social Services and the Deputy Minister for Health and Social Services.

36. Special Advisers are not decision makers. Special Advisers add a political dimension to the advice and assistance available to ministers while reinforcing the political impartiality of the permanent Civil Service by distinguishing the source of political advice and support.

37. Special Advisers are appointed by the First Minister to help ministers on matters where the work of the Welsh Government and the work of the government party overlap and where it would be inappropriate for permanent civil servants to become involved. They are an additional resource for ministers aiding from a standpoint that is more politically committed and politically aware than would be available to a minister from the permanent Civil Service.

38. Special Advisers are employed as civil servants but are subject to a separate Code of Conduct. The Code of Conduct for Special Advisers is exhibited in **AGM3WGO01/12-INQ000222866**.

39. The Health and Social Services Group worked primarily with Clare Jenkins during the pandemic period but would also provide updates to or receive information from the First Minister's Special Advisers, Jane Runeckles and Madeleine Brindley.

Director General, Health and Social Services and the Chief Executive of NHS Wales

40. The Director General Health and Social Services holds a combined role as Director General and a role referred to as the "Chief Executive NHS Wales". I held the position of the Director General and Chief Executive NHS Wales from June 2014 to November 2021 after which I took up the position of Permanent Secretary. I was succeeded as Director General by Judith Paget in November 2021 initially on a temporary basis before taking up the permanent position on the 1 June 2023 following a formal recruitment process.

41. While the role of Chief Executive NHS Wales is not a statutory role it is a significant and distinctive post located in the Welsh Government, bringing together the responsibilities of a Director General in the Welsh Government with the leadership and oversight of NHS Wales.

42. The Chief Executive NHS Wales role involves the leadership and oversight of appropriate planning, delivery and assurance across NHS Wales, working with all NHS organisations. The Chief Executive NHS Wales provides leadership and support to the seven Chief Executives of the local health boards, the three NHS Trust Chief Executives, two special health authorities Chief Executives and the Director of NHS Wales Shared Services Partnership. The role acts as the system leader for NHS Wales, overseeing those organisations responsible for more than 100,000 staff delivering NHS care and services across Wales.

43. The Chief Executive NHS Wales is accountable to the Minister for Health and Social Services for the oversight and performance of NHS Wales, and responsible for providing policy advice and exercising strategic leadership and management of the NHS in Wales. As such, the role aligns closely with that of the Director General Health and Social Services, as the senior civil servant in the Welsh Government's Health and Social Services Group.

44. As Chief Executive NHS Wales I discharged duties on behalf of the Welsh Ministers but through this role I was also Accounting Officer for NHS Wales, a role designated by the Welsh Government's Permanent Secretary[5]. I will detail this further below, but this role acted as an important lever over the performance and leadership of NHS organisations in Wales as the individual chief executives of these organisations financially reported to myself and I in turn had a responsibility to account for the NHS expenditure. As such, the role aligns closely with that of the Director General , as the senior civil servant in the Health and Social Services Group.

45. This role is a unique one as a bridge between NHS Wales and the Welsh Ministers. A particular, (and defining) feature of the Welsh public healthcare sector is that, consisting only of 12 bodies, it is intimate. A formal mechanism of providing this leadership role and bringing together the Director General role was via the NHS Wales Executive Board (later known as the NHS Wales Leadership Board). The purpose of this Board is to provide executive leadership, direction and oversight of the performance, delivery, quality and safety of NHS services, workforce and functions in Wales. As I have sought to outline in this statement, the NHS system in Wales operates as a collaborative, planned system in which outcomes will be maximised if organisations work together in a "one Wales" approach. The Board provides the leadership forum to support the "one Wales" approach to the oversight and delivery of NHS functions in Wales. The Board is attended by the Welsh Government's Health and Social Services Group Directors and the local health boards, Trusts and Special Health Authorities' Chief Executives.

46. During the pandemic we were able to use existing arrangements between the Welsh Government and NHS Wales for regular and effective two-way communication to identify and resolve problems quickly, although these were enhanced and introduced urgently when needed outside of the routine pre-pandemic cycle. This proximity of the healthcare system to government enabled speedy contact and discussion when needed, with organisations, stakeholders and professional representatives. This put us in a strong position in terms of existing relationships and mechanisms when the pandemic hit, and we have sought to learn from this, as I will outline further below.

Welsh Government Health and Social Services Group Senior Civil Servants

[5] In accordance with section 133 of the Government of Wales Act 2006

47. The Health and Social Services Group sets out the Minister for Health and Social Services expectations in respect of planning and performance and the assurance it seeks from NHS organisations through its planning, delivery and compliance frameworks.

48. The Health and Social Services Group is also the link between the local authorities' social services directors and the Minister for Health and Social Services and Deputy Minister for HSS.

49. The Health and Social Services Group has the following overarching responsibilities:

    a) promoting, protecting, and improving the health and well-being of everyone in Wales, and leading efforts to reduce inequalities in health.

    b) making available a comprehensive, safe, effective, and sustainable NHS.

    c) ensuring that high quality social services are available and increasingly joined up with health care and other services.

    d) ensuring that through Cafcass Cymru, children are put first in family proceedings, their voices are heard, and decisions made about them by courts are in their best interests.

50. Prior to the pandemic the Health and Social Services Group consisted of the following directorates/divisions:

    a) Cafcass Cymru.

    b) Delivery, Performance and Planning for health and care in Wales.

    c) Finance.

    d) Mental Health, Vulnerable Groups and NHS Governance.

    e) Nursing.

    f) Population Health (including Chief Medical Officer's Office).

g) Primary Care and Health Science.

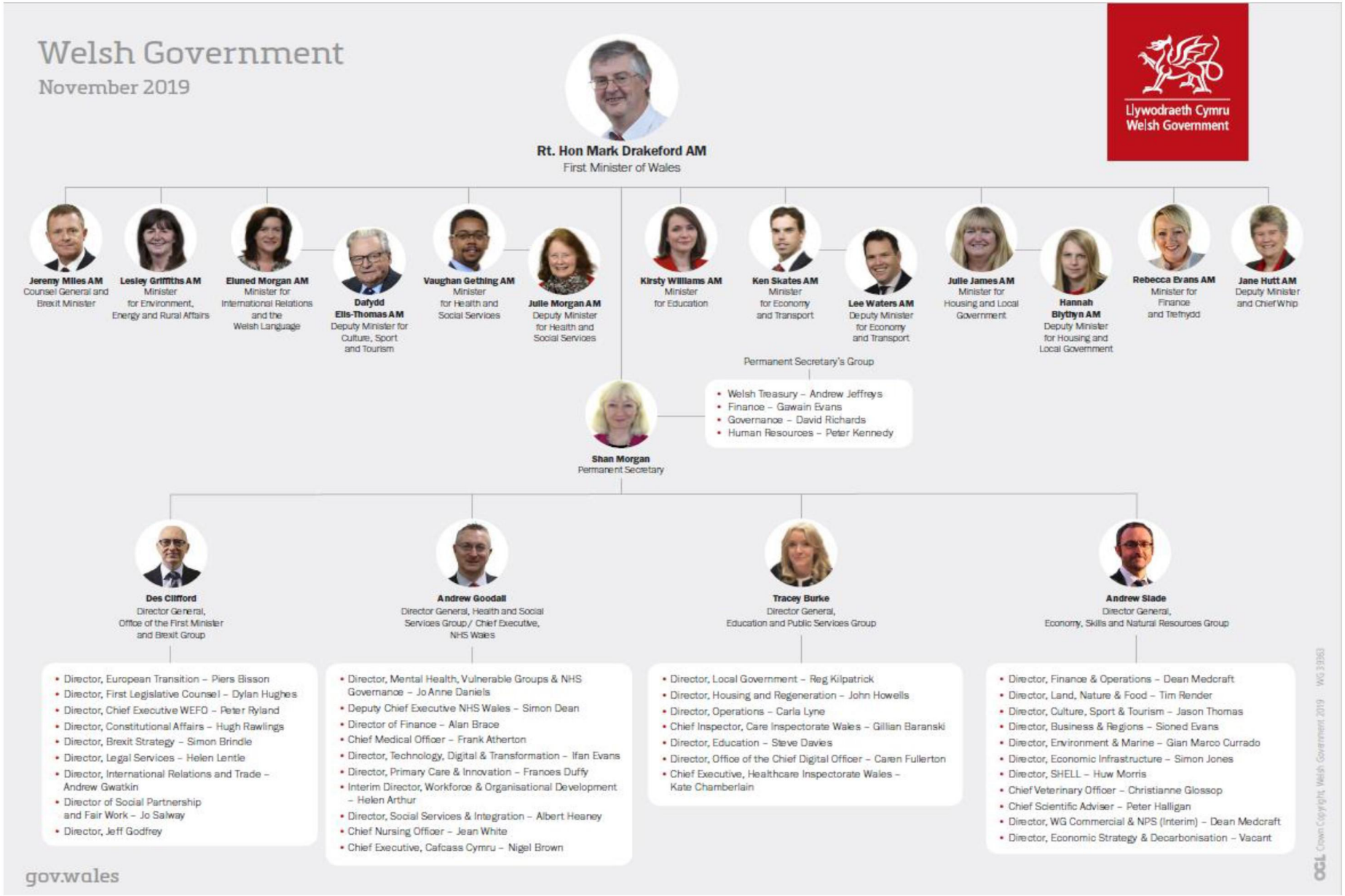
h) Social Services.

i) Technology, Digital and Transformation.

j) Workforce and Organisational Development.

The structure of the Welsh Government and the Directors within the Health and Social Services Group as of November 2019, prior to the pandemic is set out in the organogram on the following page.

Organogram 1 – November 2019 Welsh Government



51. Officials across the Health and Social Services Group engage with ministers via meetings and email correspondence. The formal method of advising is via the Ministerial Advice process which provides a channel for ministers to make decisions relevant to their portfolio which do not require a Cabinet collective discussion or decision. A Ministerial Advice ("MA") document is a document submitted to relevant ministers for the purpose of providing them with information advice and options, to enable them to make a Ministerial decision. An MA is submitted to Ministers when providing formal advice relating to a new decision, relating to policy, operations, legislation or such other matter upon which a Minister is invited to make a decision. Each MA is allocated an MA number which is obtained from the Ministerial Advice Tracking System (MATS).

52. An MA should set out how the topic it addresses contributes to the delivery of the Programme for Government and the well-being objectives of the Welsh Government. In respect of particularly complex or controversial decisions, engagement with Private Office, Special Advisers or the Minister would take place in advance of submitting an MA.

53. A Decision Report is published on the Welsh Government's website for all MAs where a Minister has taken a substantive decision. A Decision Report is a short summary of the issue and the Minister's response to a recommendation. A list of all MAs issued by the Health and Social Services Group during the pandemic period within the scope of Module 3 is exhibited in **AGM3WGO01/13 - INQ000227436.**

54. The focus of Module 3 and the Inquiry's request referenced M3-WGO-01 is based on the healthcare system in Wales but, as outlined above, it is important to note that the role of the Health and Social Services Group is to focus on supporting the Welsh Government to deliver its priorities whilst also providing leadership to both the NHS and the social services system in Wales. The social services system will I understand be considered in more detail in later modules.

The Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer and Chief Scientific Adviser for Health

55. The Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer and Chief Scientific Adviser for Health are all members of the Health and Social Services Group and worked closely with officials with the Health and Social Services Group and had Directorate responsibility for key areas which were affected by or part of the pandemic response.

Chief Medical Officer

56. The Chief Medical Officer post in Wales is a director level post which reports to the Director General of the Health and Social Services Group who in turn reports to the Permanent Secretary. The Chief Medical Officer provides independent professional advice and guidance to the Welsh Government's Cabinet, the Minister for Health and Social Services, the Deputy Minister for Health and Social Services, and their officials on matters relating to health strategy, public health, quality and safety and research and development. The Chief Medical Officer is also the Medical Director for NHS Wales and provides professional leadership at the national level and within the Welsh Government for the medical profession.

57. During the pandemic period and within the scope of Module 3 the Chief Medical Officer for Wales was responsible for shielding of the clinically vulnerable and clinically extremely vulnerable, medical leadership within healthcare systems, healthcare systems' response to clinical trials and research during the pandemic and preventing the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital.

Chief Nursing Officer

58. The Chief Nursing Officer for Wales is a director level appointment in the Senior Civil Service. It also includes the title of Nurse Director of NHS Wales. The role of Chief Nursing Officer for Wales and Nurse Director, NHS Wales entails setting the professional agenda and future direction for the nursing and midwifery professions in Wales and acting as a senior adviser to the Welsh Ministers on all matters relating to nursing and midwifery practice and education. This includes providing leadership,

advice, guidance, and support for delivery of the Welsh Ministers' priorities for nursing and midwifery in Wales.

59. During the pandemic period and within the scope of Module 3 the Chief Nursing Officer for Wales was responsible for nursing and midwifery care within healthcare systems, and from a nursing care perspective, prevention of the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital. The Chief Nursing Officer chaired the Nosocomial Transmission Covid-19 Group ("NTG") with Dr Chris Jones, the Deputy Chief Medical Officer for Wales ("DCMO(W)"). This group had wide health and social care membership and produced a range of guidance and advice for NHS and social care settings.

Chief Pharmaceutical Officer

60. The Chief Pharmaceutical Officer the Welsh Government's principal advisor on all aspects of pharmacy practice, prescribing and medicines related issues. The Chief Pharmaceutical Officer leads the strategic development and provides exemplary, impartial, and authoritative advice across the 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, the role provides 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.

61. The Chief Pharmaceutical Officer's primary role during the pandemic included ensuring patients access to medicines, access to the community, repurposing of appropriate medicines identified as beneficial in the treatment or prophylaxis of Covid-19 and for work 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.

Chief Scientific Adviser for Health

62. The Chief Scientific Adviser for Health is responsible for the science advice provided to the Welsh Government and the Welsh Ministers. In terms of the healthcare system they provide clinical leadership working with local health boards directors of therapies and Health Science to develop implement and evaluate Health Science strategies to ensure developments across the full spectrum of health and social care reflect Health Science contributions and align with the Welsh Government policies. The Chief Scientific Advisor also supports the development of new technologies and promotes evidence based practise and high quality research activity among therapy and Health Science staff to ensure prudent health and care principles are embedded into daily practice.

63. During the pandemic period and within the scope of Module 3 the Chief Scientific Advisor for Health was responsible for the provision of advice and guidance on emerging data and information of the incidence and spread of Covid-19 which would be fed into the planning for NHS services in Wales and support the work of the Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer.

Funding and planning health services in Wales

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

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

    b) Funds raised in Wales by means of taxation and other charges.

    c) Borrowing; and

d) EU funding.

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

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

67. The Welsh Government's budget is organised by Main Expenditure Groups ("MEGs"), which broadly mirror ministerial responsibilities. That provides clear lines of financial accountability at Cabinet and to the Senedd. The minister with responsibility for finance is responsible for agreeing the MEG budget structure. The Health and Social Services Group MEG is the responsibility of the Minister for Health and Social Services. Funding levels for specific spending programmes within the Health and Social Services Group MEG is set by the Minister for Health and Social Services although additional funding is sometimes allocated directly to specific spending programmes by the Minister for Finance. The Health and Social Services Group MEG was the largest MEG within the Welsh Government's budget for 2018-19. The allocation within it was £7,820 million, representing approximately 48% of the Welsh Government's budget.

68. The Welsh Ministers are under statutory duties to fund NHS Wales[6]. The NHS in Wales is funded almost entirely from the Welsh Government's Health and Social Services Group MEG.

69. NHS Wales therefore receives the majority of its funding from the Welsh Government to cover the day-to-day running costs of health services in Wales during each financial year. This takes the following forms:

    a) Revenue allocations to health boards to secure hospital, community and primary care services for their resident populations including GPs, General Dental Practitioners and Pharmacists.

    b) Capital allocations to health boards and NHS trusts for operational and strategic capital developments; and

    c) Targeted funding for health improvement and other Welsh Government initiatives.

70. The publication "Managing Welsh Public Money" (January 2016) which I produce as exhibit **AGM3WGO01/14 - INQ000116472** sets out the main principles of ethical financial management for public sector organisations in Wales, including the Health and Social Services Group and NHS in Wales. Managing Welsh Public Money should be read in conjunction with Managing Public Money (published by HM Treasury) to understand the wider picture of funding and financial control at a UK level. A copy of the HM Treasury document is exhibited at **AGM3WGO01/15 - INQ000279942[7].**

71. As outlined above, the Chief Executive NHS Wales is also designated by the Welsh Government's Permanent Secretary[8] as the "Accounting Officer for NHS Wales". The Chief Executives of the individual NHS bodies in Wales have a duty to their respective boards and, as the Accountable Officers for those organisations, to the Chief Executive NHS Wales as Additional Accounting Officer for NHS Wales. That relationship is governed by an Accountable Officer Memorandum issued by the Chief Executive NHS Wales. A copy of this Memorandum is exhibited as **AGM3WGO01/16 - INQ000227415.** This Memorandum outlines the responsibility of the Accountable

[6] See 2006 Act Schedule 4 (trusts), section 171 (SHAs) and section 174 (Health Boards)
[7] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227416]
[8] In accordance with section 133 of the Government of Wales Act 2006

Officer in each NHS organisation for financial management/performance. The Memorandum sets out that the Accountable Officer is directly accountable, for all financial performance issues (and all other performance issues) delegated to the organisation, and to the Chief Executive NHS Wales as Additional Accounting Officer for Health and Social Services.

72. NHS bodies are required to prepare annual accounts.[9] Summarised Accounts of the local health boards, NHS Trusts and special health authorities are prepared each year in compliance with the accounting principles and disclosure requirements of the Government Financial Reporting Manual (FReM) issued by HM Treasury as applied to the NHS in Wales. In my capacity as Additional Accounting Officer, I would sign the NHS Wales combined summarised accounts of the local health boards and NHS Trusts and special health authorities which would be examined by the Auditor General for Wales and laid before the Senedd. The summarised accounts of local health boards, NHS Trusts and special health authorities in Wales for the year ending 31 March 2020 are exhibited in **AGM3WGO01/17 - INQ000182519.**

73. NHS Wales operates under the Welsh Government's NHS Wales Planning Framework which gives statutory guidance on developing three-year plans linked to an NHS body's allocated budget, known as Integrated Medium Term Plans ("IMTPs") setting out how the NHS body will deliver services to meet the needs of their local population. The Welsh Ministers approve the annual IMTPs for each local health board and trust in Wales, and the local health boards and trusts deliver agreed plans within their allocated budgets. The Welsh Ministers report to the Senedd before the end of any three-year accounting period on the local health board's and trust performance[10]. While special health authorities and the other various committees and organisations which form part of NHS Wales are not under the same statutory planning duty, following approval by their respective committees and Boards, IMTPs are also submitted by these NHS organisations on a voluntary basis providing plans in the spirit of the Framework.

74. The NHS Planning Framework is a significant part of the oversight and monitoring of the NHS by the Welsh Ministers and the vehicle for setting the policy direction for the

[9] Paragraph 3 of Schedule 9 to the NHS (Wales) Act 2006.
[10] Under section 175(1) of the 2006 Act.

NHS in Wales. An IMTP responds to Ministerial and governmental priorities and is one of the key enablers to achieving high-performing, timely, safe and sustainable services. IMTPs must demonstrate an integrated planning approach, which links to the population needs all set within the organisations longer term clinical services strategy. IMTPs must also align with 'Area Plans' developed with Regional Partnership Boards[11], Well-being plans developed by Public Service Boards[12] and Mental Health Delivery Plans.[13]

75. Following submission of an IMTP, based on recommendations from Welsh Government officials, Ministers will make a decision on whether or not to approve the plan. If approved the Chief Executive NHS Wales will issue an accountability letter setting out any conditions for the year ahead. If the plan is not approved the NHS body will need to provide a detailed Annual Operating Plan to provide assurance and ensure smooth and sustainable provision of services to its population over the year ahead and appropriate monitoring and escalation arrangements will be put in place to oversee delivery.

Accountability to Senedd

76. The Minister for Health and Social Services is accountable to the Senedd for the performance of the Welsh Ministers responsibilities under the NHS (Wales) Act 2006 in relation to the health care system in Wales. The Senedd exercises scrutiny of ministerial decisions, policy, government bills and subordinate legislation via its plenary proceedings and through the work of its committees and sub committees established pursuant to section 28 of the Government of Wales Act 2006 and the Senedd's Standing Orders.

77. The Senedd has established a number of cross-party committees, which examine Government policies and proposed legislation. Committees can also instigate their own inquiries into subjects which affect Wales, and even propose their own legislation.

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[11] Under the 2014 Act

[12] Under the Well-being of Future Generations Act (Wales) 2015. For the avoidance of doubt, whilst WAST is currently not formally subject to the Well-being of Future Generations Act, it is expected to reflect the ambition of the Act and delivery in its IMTP.

[13] In accordance with the Welsh Government's Together for Mental Health Strategy.

The main committees which the Minister for Health and Social Services and Health and Social Services Group engages with in respect of healthcare systems are:

a) Health Social Care and Sports Committee

b) Children, Young People and Education Committee

c) Public Accounts Committee.

78. The role of the Public Accounts Committee is to carry out examinations into the economy, efficiency, and effectiveness with which the Welsh Ministers have used their resources. In order to undertake this role, the Committee will normally invite the Accounting Officers to review the reports. As the Permanent Secretary I attend as the Principal Accounting Officer for the Welsh Government, and I previously attended as the Accounting Officer for the NHS. The Senedd also meets in Plenary. This is a meeting of all members and is the main forum for holding the Government to account. Members do this through questions to Ministers, debates and voting on issues affecting everyday life in Wales.

79. Exhibit **AGM3WGO01/18 - INQ000088014** provides a list of all attendances at Senedd Committees by the Minister for Health and Social Services or Health and Social Services Group officials for the pandemic period.

The National Health Service in Wales

80. The NHS in Wales is principally made up of three types of statutory bodies (local health boards, trusts and special health authorities) and is supported in the performance of their legal responsibilities by a number of Wales wide committees and hosted organisations. NHS bodies in Wales have legal responsibility for the delivery of health care services. The Welsh Ministers fund the NHS in Wales, set high level policies and the strategic direction for the system, as well as approve each NHS body's plan on how they will fulfil their legal responsibilities and monitor their performance (through the IMTP process outlined above at paragraphs 73 to 75).

Local health boards in Wales

81. In Wales, healthcare services are primarily delivered by local health boards who are responsible for planning, securing and delivering all healthcare services for the benefit of their resident population in a specific geographical area. This includes primary, community, acute and mental health services. There are currently seven local health boards in Wales:

    a) Aneurin Bevan University Local Health Board (covering Newport, Torfaen, Monmouthshire, Caerphilly and Blaenau Gwent local authorities.

    a) Betsi Cadwaladr University Local Health Board (covering Flintshire, Denbighshire, Gwynedd, Wrexham, Conwy and Anglesey local authorities).

    b) Cardiff and Vale University Local Health Board (covering Cardiff and Vale of Glamorgan local authorities).

    c) Cwm Taf Morgannwg University Local Health Board (covering Bridgend, Merthyr Tydfil and Rhondda Cynon Taf local authorities).

    d) Hywel Dda University Local Health Board (covering Carmarthenshire, Pembrokeshire and Ceredigion local authorities).

    e) Powys Teaching Local Health Board (covering Powys).

    f) Swansea Bay University Local Health Board (covering Neath Port Talbot and Swansea local authorities).

82. The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 sets out the detailed requirements for the constitution and membership of local health boards in Wales. The principal functions of local health boards are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009,[14] which are regulations made by the Welsh Ministers in exercise of their powers under section 12 of the 2006 Act. The Welsh Ministers delegated to local health boards functions under the 2006 Act as well as under six other statutes.[15] These

[14] SI 2009/1511
[15] See Schedule 1 of Local Health Boards (Directed Functions) (Wales) Regulations 2009/1511

functions include the Welsh Ministers' general duty under section 1 of the 2006 Act to continue to promote and provide comprehensive health service in Wales. The powers exercised by local health boards pursuant to such delegation (subject to certain exceptions) are in respect of those persons usually resident in the area for which the local health board is established. In addition to those functions delegated by the Welsh Ministers, parts 4 to 7 of the 2006 Act impose specific duties on local health boards in relation to the provision of medical and dental services.

83. The Regulations made in 2009 were made as part of a wider reorganisation of the NHS in Wales. Prior to the changes, which came into force on 1 October 2009, there were 22 local health boards in Wales, and the role of the local health boards in Wales was effectively limited to the commissioning of health services, while the Welsh NHS Trusts had the function of providing 'front-line' medical services in Wales. However, the 2009 changes introduced an integrated healthcare system in Wales, under which local health boards were made responsible for commissioning and providing primary, secondary and tertiary healthcare services for their resident population.

84. Under the 2006 Act, where functions have been delegated it does not however prevent the Welsh Ministers from exercising the function in respect of Wales[16]. Therefore, while the duties are imposed on the Welsh Ministers, they have chosen to discharge that statutory duty by establishing local health boards and making each responsible for healthcare functions under the 2006 Act in relation to their area. The Welsh Ministers however retain certain monitoring and intervention functions, which, in appropriate circumstances, might be invoked if the responsible delegate does not properly perform the delegated duty.

85. In terms of operational decision-making in relation to the healthcare system during the relevant period this was principally the responsibility of the local health boards however the Welsh Ministers have the power to issue directions to the local health boards in relation to how they meet their statutory duties under the 2006 Act.

[16] Section 31 of the NHS (Wales) Act 2006

NHS Trusts in Wales

86. As part of the reorganisation on 1 October 2009, seven trusts which previously delivered hospital services were dissolved with the exception of the Welsh Ambulance Services NHS Trust ("Welsh Ambulance Service") and Velindre NHS Trust ("Velindre") which continued in existence.

87. Public Health Wales NHS Trust ("Public Health Wales") was established on the 1 October 2009 as a new unified Public Health organisation.[17] The functions of Public Health Wales set out in statute are:

    a) Provide and manage public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;

    b) Develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;

    c) Undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and

    d) Provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.

88. Public Health Wales is the national public health agency in Wales. One of its roles is to protect the public from infection and to provide advice to the public, the NHS bodies, and the Welsh Government.

89. The Welsh Ambulance Service was established pre-devolution on the 1 April 1998,[18] with the management of NHS Direct Wales being transferred to WAST in April 2007. The Welsh Ambulance Service is the sole national provider of 999 Emergency Medical

[17] Public Health Wales National Health Service Trust (Establishment) Order 2009/2058
[18] The Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998. S.I. 1998/678.

Services ("EMS") in Wales, provides the call handling, clinical assessment and advice functions of the NHS 111 Wales service, and provides a non-emergency patient transport service ("NEPTS").

90. Velindre University NHS Trust was established on 1 April 1994[19] and at that time was a single specialty trust providing only cancer services. Over the years, the trust has significantly evolved and expanded. The main function of Velindre is to provide all-Wales and regional clinical health services to the NHS and the people of Wales. Velindre consists of two clinical divisions: Velindre Cancer Centre and the Welsh Blood Service. The latter works with its UK counterparts both formally and informally to ensure the safety of the blood supply chain. Velindre also hosts NHS Wales Shared Services Partnership ("NWSSP"), and until 1 April 2021 Velindre hosted NHS Wales Informatic Services ("NWIS"). On 1 April 2021 NWIS's functions were transferred to Digital Health and Care Wales ("DHWC"), a new special health authority. Hosted organisations have their own Board or committee where the more detailed discussions, review and approval of strategy and performance takes place. Velindre is accountable for the statutory, legal and compliance framework.

91. Both Welsh Ambulance Service and Velindre's membership and procedures are contained in the NHS Trusts (Membership and Procedure) Regulations 1990.[20] Public Health Wales has separate provision in the Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009.[21]

Special Health Authorities in Wales

92. There are two Welsh special health authorities: Health Education and Improvement Wales ("HEIW") and Digital Health and Care Wales ("DHCW").

93. HEIW was established in 2018[22] and its functions relate to the planning, commissioning and delivery of education and training for the Welsh health workforce. This was the first Welsh special health authority established by the Welsh Ministers.

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[19] Velindre National Health Service Trust (Establishment) Order 1993/2838 (as amended).
[20] National Health Service Trusts (Membership and Procedure) Regulations 1990 S.I. 1190/2024 (as amended).
[21] The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009. S.I. 2009 as amended.
[22] Health Education and Improvement Wales (Establishment and Constitution) Order 2017/913.

94. DHCW was established in 2020[23] and became operational in 2021. DHCW has such functions as the Welsh Ministers may direct in connection with the following areas:

    a) The provision, design, management, development and delivery of digital platforms, systems and services;
    b) The collection, analysis, use and dissemination of health service data;
    c) The provision of advice and guidance to the Welsh Ministers about improving digital platforms, systems and services;
    d) Supporting bodies and persons identified in directions given by the Welsh Ministers to DHCW in relation to matters relevant to digital platforms, systems and services;
    e) Any other matter so as to secure the provision or promotion of services under the 2006 Act.

95. There are also two joint special health authorities operating on an England and Wales basis: the NHS Business Services Authority ("NHSBSA") and NHS Blood and Transplant ("NHSBT"). NHSBSA[24] and NHSBT[25] are established jointly by the Secretary of State and the Welsh Ministers. As these are joint special health authorities the Welsh Ministers may direct the NHSBSA or NHSBT to exercise any of the functions of the Welsh Ministers relating to the health service in Wales which are specified directions made under the 2006 Act.

NHS Wales working together

96. The 2006 Act provides a number of legislative mechanisms to enable the NHS bodies to work together with other bodies both inside and outside Wales. Local health boards in particular have broad powers to make arrangements with any person or body to provide or assist in providing services under the Act;[26] to exercise their functions jointly with a range of bodies including other local health boards, Trusts, NHS Commissioning Board or Integrated Care Boards (following the abolition of Clinical Commissioning Groups pursuant to s.14Z27 of the NHS Act 2006)[27] and they may also be directed by

[23] Digital Health and Care Wales (Establishment and Membership) Order 2020/1451.
[24] The NHS Business Services Authority (Awdurdod Gwasanaethau Busnes y GIG) (Establishment and Constitution) Order 2005.
[25] The NHS Blood and Transplant (Gwaed a Thrawsblaniadau'r GIG) (Establishment and Constitution) Order 2005.
[26] Section 10 of the NHS (Wales) Act 2006.
[27] Section 13 of the NHS (Wales) Act 2006.

the Welsh Ministers for their functions to be exercised by committees or by a special health authority.

97. In addition to the three main types of statutory NHS bodies there are a range of committees, partnerships, associations and hosted bodies in place which also service and form part of NHS in Wales. These bodies and a description of their role and functions are set out below:

NHS Wales Shared Services Partnership ("NWSSP")

98. Velindre NHS Trust has the function of managing and providing shared services to the health service in Wales. NWSSP is the operational name for the Shared Services Committee of Velindre NHS Trust. This organisation is also sometimes referred to as "Shared Services". NWSSP is a hosted organisation and is responsible for exercising Velindre National Health Service Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local health boards and National Health Service Trusts". NWSSP has a designated Accountable Officer for Shared Services and is accountable to the Welsh Ministers. NWSSP produces its own Annual Governance statement.

99. NWSSP functions include functions directed by the Welsh Ministers such as payroll services, procurement services, and legal services for NHS bodies in Wales. The NHS bodies have also collectively agreed to transfer services to NWSSP such as health courier services, laundry services, and student award schemes. NWSSP delivers a wide range of high quality, professional, technical, and administrative services for and on behalf of NHS Wales also working with the wider public services, including Welsh Government.

Joint Committee Welsh Health Specialised Services Committee ("WHSSC")

100. The Welsh Health Specialised Services Committee is a joint committee of each local health board in Wales, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning and securing of certain specialised and tertiary services on a national all-Wales basis, on behalf of each of the seven local health boards in Wales. The WHSSC Standing Orders, Standing Financial Instructions and the Memorandum of Agreement agreed

with the seven local health boards and approved by the joint committee, set out the governance framework for its operation.

101. Local health boards are responsible for the provision of health services for those people who are resident in their local area. Whilst WHSSC acts on behalf of the seven local health boards in undertaking its functions, the duty on individual local health boards remains, and they are ultimately accountable to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area.

Joint Committee Emergency Ambulance Service Committee ("EASC")

102. The Emergency Ambulance Services Committee is a joint committee which has the responsibility to 'plan and secure emergency ambulance services for the sick and injured'. The EASC was established on 1 April 2014. In December 2015, the Welsh Ministers directed local health boards to be responsible for commissioning Non-Emergency Patient Transport Services (NEPTS) via the Emergency Ambulance Services Committee from April 2016.

103. The arrangements effectively create a commissioner /provider relationship in which the seven local health boards are collectively responsible for securing the provision of an effective emergency ambulance service, and NEPTS service, for Wales. WAST, therefore, is responsible for supplying the urgent and emergency medical services, and NEPTS, based on a robust commissioning framework. The National Collaborative Commissioning Unit (NCCU) is responsible for delivering national commissioning programmes. NCCU was established by the Minister for Health and Social Services in 2015 to improve patient outcomes and experience through the services it delivers aiming to "Lead quality assurance and improvement for NHS Wales through collaborative commissioning". NCCU is established under the organisational arrangements of EASC. EASC is hosted by Cwm Taf University Health Board on behalf of local health boards in Wales.

National Imaging Academy Wales ("NIAW")

104. The National Imaging Academy Wales was established in 2018 and is a purpose-designed state of the art facility to deliver the highest level of training to generate consultant radiologists to meet the increasing pressures imaging professions are facing. The National Imaging Academy has an annual work plan and performance

management arrangements that are agreed between the Director of the National Imaging Academy and the Collaborative Executive Group, prior to final sign off by the Collaborative Leadership Forum. The National Imaging Academy is hosted by Cwm Taf University Health Board on behalf of local health boards and Trusts in Wales.

Welsh Risk Pool Service ("WRPS")

105. The WRPS is part of the NHS Wales Shared Service Partnership Legal and Risk Service. It provides indemnity to all local health boards and NHS Trusts in Wales for clinical and non-clinical claims for negligence. The WRPS was established in 1996 when responsibility for meeting the cost of clinical negligence claims was transferred directly to NHS Wales. The WRPS arrangements are contained in various Welsh Health Circulars and NHS guidance.

NHS Delivery Unit ("NHSDU")

106. The NHS Delivery Unit was formerly the Delivery and Support Unit and was established in 2005. The Delivery Unit is a non-statutory body hosted by Swansea Bay University Health Board. The purpose of the Delivery Unit is to provide the Welsh Government and the NHS with additional capacity and operational expertise and also provide expertise and advice to the Welsh Government on policy development matters, including the development of a wider suite of performance management and improvement tools and techniques. The Delivery Unit is accountable to the Director of Health and Social Services Group in the Welsh Government.

NHS Finance Delivery Unity ("FDU")

107. The creation of the Finance Delivery Unit was announced by the Cabinet Secretary for Health and Social Services in 2017. The purpose of the Finance Delivery Unit is to enhance the capacity to monitor and manage financial risk in NHS Wales and to respond at pace where organisations are demonstrating evidence of potential financial failure; and accelerate the uptake across NHS Wales of best practice in financial management and technical and allocative efficiency. The Finance Delivery Unit is accountable to the Director of Finance, Health and Social Services Group in the Welsh Government and the annual work programme is agreed and monitored through regular meetings with the Welsh Government. The Finance Delivery Unit is hosted by Public Health Wales on behalf of the Health and Social Services Group.

NHS Wales Health Collaborative

108. The NHS Wales Health Collaborative is a national body, working on behalf of the local health boards, Trusts and special health authorities that make up NHS Wales. Through facilitating engagement, networking and collaboration between NHS Wales partners and other stakeholders, the Collaborative works to support the improvement of NHS Wales's services across organisational boundaries and improve the quality of care for patients. The Collaborative covers a broad range of clinical networks, national programmes and projects, major conditions implementation groups, and support functions. The Collaborative is hosted by Public Health Wales, on behalf of NHS Wales.

NHS Wales Informatics Service ("NWIS")

109. NWIS was a non-statutory organisation hosted by Velindre NHS Trust from April 2010 to 31 March 2021. The Velindre National Health Service (Establishment) Order 1993 (as amended) sets out the Trust's functions given to them by the Welsh Ministers which includes: "to manage and provide to or in relation to the health service in Wales a range of information technology systems and associated support and consultancy services, desktop services, web development, telecommunications services, healthcare information services and services relating to prescribing and dispensing". NWIS delivered these services across NHS Wales as part of Velindre NHS Trust. NWIS functions were transferred to DHCW when it was established as a SHA and became operational in 2021. NWIS staff and services were transferred to DHCW entirely from 1 April 2021.

NHS Wales Improvement Cymru

110. Improvement Cymru is the all-Wales Improvement service for NHS Wales. Its objective is to support the creation of the best quality health and care system for Wales so that everyone has access to safe, effective and efficient care in the right place and at the right time. It is part of Public Health Wales and is made up of experts in developing, embedding, and delivering system-wide improvements across health and social care. Improvement Cymru works closely with NHS Wales to support them to continually improve what they do and how they do it to help create a healthier Wales.

Emergency Medical Retrieval and Transfer Service

111. The Emergency Medical Retrieval and Transfer Service Cymru (EMRTS Cymru) is a pre-hospital critical care service in Wales. It is partnership between Wales Air Ambulance, Welsh Government and NHS Wales.

Welsh NHS Confederation

112. The NHS confederation is a membership organisation with funding contributions from all health organisations. The Welsh NHS Confederation is also part of the national UK wide NHS Confederation and host NHS Wales Employers. This organisation represents the seven local health boards; three NHS Trusts; Health Education and Improvement Wales; and Digital Health and Care Wales. While it is not part of Welsh Government's management structure for NHS Wales it is part of the NHS Wales network and collaborative arrangements. The Welsh NHS Confederation is governed by a Management Committee comprising the chairs and chief executives of the seven local health boards, three NHS Trusts, two SHAs in Wales and the director of the Welsh NHS Confederation.

Regional Partnership Boards

113. In addition to the NHS Wales bodies and organisations, Regional Partnership Boards ("RPBs") have been established to support the requirement for co-operation and partnership working between local health boards and local authorities as part of the Social Services and Well-Being (Wales) Act 2014 ("the 2014 Act") to improve the well-being of the population and to improve how health and care services are delivered. The RPBs help to oversee and ensure integrated planning across health and social care by local health boards and their local authority partners who are required under the 2014 Act to:

    a) produce regional population assessments;
    b) produce a regional area plan;
    c) provide a regional annual report;
    d) demonstrate citizen engagement and co-production.

114. There are 7 RPBs linked to the Health Board regional footprints:

        i. Cardiff & Vale Regional Partnership Board;

ii. Cwm Taf Morgannwg Regional Partnership Board;

iii. Gwent Regional Partnership Board;

iv. West Wales Regional Partnership Board;

v. North Wales Regional Partnership Board;

vi. West Glamorgan Regional Partnership Board;

vii. Powys Regional Partnership Board.

Public Service Boards

115. NHS Wales is also required to work in co-operation and collaboration with other public bodies to improve the social, economic, environmental and cultural well-being of Wales. The Well-being of Future Generations (Wales) Act 2015 provides a legally binding common purpose – the 'seven well-being goals' – for public bodies in Wales and places on specified public bodies, including local health boards, a duty to act jointly via 'Public Services Boards' ("PSBs") to improve the well-being of their area by contributing to the achievement of the well-being goals. PSBs are established for each local authority area in Wales with the following being statutory members of each PSB:

a) Local authority
b) Local health board
c) Fire and rescue authority
d) Natural Resources Wales

116. In addition, the following are invited to participate:

a) Welsh Ministers
b) Chief constables
c) Police and crime commissioner
d) Relevant probation services
e) At least one body representing voluntary organisations.

117. Each PSB must carry out a well-being assessment and publish an annual local well-being plan. The plan sets out how they will meet their responsibilities under the Well being of Future Generations (Wales) Act 2015.

Governance of NHS Wales

118. Each NHS body is responsible for ensuring appropriate governance arrangements are in place to maintain effective operation and delivery of health services to the people of Wales. The 2006 Act permits the Welsh Ministers to give directions and make regulations with respect to the exercise of NHS bodies discharging delegated functions. In addition to statutory instruments, Welsh Ministers may issue Guidance and instructions in the form of

    a) Welsh Health Circulars – (these have previously also been referred to as Ministerial Letters) as a mechanism for the Minister to issue guidance to NHS bodies on a wide range of issues; and

    b) Accountable Officer Letters – these are used to provide specific direction or advice on issues of accountability, regularity and propriety and annual accounting exercises.

119. NHS bodies have a legal duty to comply with any direction issued by Welsh Ministers. Certain directions may be given by regulations or an instrument in writing.[28] It follows that a Welsh Health Circular containing instructions for compliance as to the exercise of health functions by the NHS in Wales (i.e. by way of direction) has the same legal standing as if the direction were made by regulations and should be treated as mandatory.

120. The Welsh Government's Health and Social Services Group may also issue information by way of Welsh Health Circulars or other guidance to NHS bodies to support a key policy requirement or provide good practice guidance on a particular aspect of business. Such information or guidance (if not issued by way of direction) is non-mandatory but is expected to be followed unless there is a good reason.

[28] S.204(3)(c) of the 2006 Act specifies that certain directions [e.g. under s.12(1)(b) (exercise of functions by Health Boards), s.13 (transfer of exercise of functions or joint exercise) or s.19 (exercise of functions by NHS Trusts)], may be given by regulations or an instrument in writing.

121. The Boards of NHS bodies provide internal governance; their key roles being to formulate strategy, ensure accountability (by holding the organisation to account for the delivery of the strategy) and to shape the culture of the organisation. In respect of NHS Trusts, s.18 and s.19 of the 2006 Act provide for the establishment of Trusts and the giving of directions about the exercise of functions. Specific governance provisions are set out in Schedule 3 and 4 of the 2006 Act.

122. Internal governance of local health boards is governed by Directions issued by Welsh Ministers pursuant to Schedule 2 of the 2006 Act. By s.12(3) and 13(2) of the 2006 Act, the Welsh Ministers have given directions to local health boards pursuant to the local health boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) as to how the local health boards are to be internally governed.

123. In particular, Part 2 of those Regulations make provisions:

a) for the composition and membership of the Boards (regulation 3);

b) for the appointment of their members (regulation 4);

c) for eligibility requirements for their members (regulation 5 and Schedule 2);

d) in relation to tenure of office, termination of appointment and suspension of their members (regulations 6 to 12).

124. Generally, NHS Boards in Wales are comprised of the following members:

a) The Chair – who is accountable to the Minister for Health and Social Services for the performance of the Board and its effective governance.

b) The Chief Executive – whose role is to be the Accountable Officer and be the operational leader of the organisation.

c) Executive Directors (Officer members) – who have a dual role as Board members, and operational executive leads for their part of the organisation, and where applicable, Medical Directors, Nurse Directors and Directors of Therapies having specific roles that provide a clinical voice at the Board.

d) Independent Members (Non-officer members)/Non-Executive Directors – whose role is to provide independent thinking, objectivity, scrutiny and challenge, governance and expertise.

e) Associate Members[29] – who attend Board meetings on an ex-officio basis but do not have voting rights.

125. All Board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also have a shared responsibility for ensuring that the Board operates as effectively as possible.

126. NHS bodies in Wales must agree Standing Orders that set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities. The Standing Orders also incorporate the Standing Financial Instructions and a scheme of decisions reserved to the Board and a scheme of delegations to officers and others. NHS Bodies must operate with the overarching NHS governance and accountability framework which incorporates the Standing Orders, the schedules of reservation and delegation of powers and Standing Financial Instructions with a range of other framework documents. The Welsh Ministers issue model Standing Orders under their power of direction upon which NHS Wales organisations base their own Standing Orders.

127. NHS bodies are also required to report on an annual basis in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury as applied to the NHS in Wales. This requires the production of a performance report, accountability report and financial statements (including audited annual accounts). The accountability report includes a formal statement of assurance known as the Governance Statement, signed by the Chief Executive on behalf of the organisation. The Governance Statement is a key feature of the organisation's Annual Report and Accounts. It demonstrates publicly the management and control of resources and the extent to which the body complies with its own governance requirements, including how they have monitored and evaluated the effectiveness of their governance arrangements. It is intended to bring together in one place in the annual report all disclosures relating to governance, risk and control. The statement on internal control

[29] For the avoidance of doubt, WAST do not currently have any Associate Members on its Board.

provides citizens and other stakeholders with a level of confidence in the way in which an organisation is led, the efficiency and effectiveness of its operations and ultimately, its ability to deliver its strategic vision, aims and objectives.

128. NHS organisations also produce an Annual Quality Statement which provides an opportunity for organisations to 'tell the story' of good practice and initiatives being taken forward, as well as confirming what went well and what not so well and the actions being taken as a result.

129. In addition to bBoard level reports and statements, all organisations are required to participate in the annually agreed set of national clinical audits and outcome review programmes published by the Welsh Government as well as determine their own local priorities. This needs to be complemented with a broader framework of improvement activity, incorporating actions to improve following reviews undertaken by bodies such as Healthcare Inspectorate Wales. Boards should also consider what actions and learning need to be taken across the organisation from findings in one area. All NHS organisations in Wales are required to have a Quality and Safety Committee to ensure sufficient focus and attention is given to such matters. This must be served by its independent members and report directly to the Board. Audit, Inspection and Regulation Bodies play a key role in assessing the quality of services to ensure standards are met and resources are being used effectively. This includes bodies such as Healthcare Inspectorate Wales, Llais (from 1st April 2023) - formerly Community Health Councils of Wales, Audit Wales and the Health and Safety Executive and in partnership with Care Inspectorate Wales for social care. As part of NHS Wales Shared Services, all NHS organisations have a local Internal Audit team and a Counter Fraud team.

130. Ultimately, before the pandemic period and during it, while the Welsh Ministers had responsibility for healthcare services in Wales, NHS bodies in Wales were required to deliver these services. Each local health board had responsibility for their area and trusts and special health authorities a responsibility for delivery of national services. The Welsh Ministers have legal responsibility for overseeing financial and service performance and to consider the need to intervene to support failing NHS bodies in Wales to ensure the provision of a comprehensive health service. However day to day

operational decisions and delivery of health care services are the legal responsibility of NHS bodies in Wales.

Overview of the Welsh Government plans in place for healthcare systems to deal with a pandemic such as Covid-19 as of 1 March 2020

131. In terms of the Health and Social Services Group and NHS Wales pre or early pandemic planning I am conscious that this has been covered in detail as part of Module 1 to the Inquiry which addresses pre-pandemic preparedness. I am therefore limiting the information in this statement to outlining the extant key plans, committees and groups in place immediately before the Covid-19 pandemic rather than detailing the evolution of emergency planning in Wales.

132. The Health and Social Services Group's Health Emergency Planning Unit's ("HEPU") role was to ensure appropriate contingency arrangements were in place across NHS Wales to respond to civil contingencies effectively. Located in the Public Health Division of the Chief Medical Officer's Directorate, HEPU was able to draw upon the wider health professional advice and support available in the then Health Protection Division. Additionally, HEPU provided Welsh Government oversight of the national procurement, storage, management and distribution of health countermeasures for national level risks. HEPU also undertook a monitoring and supporting role through the Wales NHS Emergency Planning Structure which brought together emergency planning representatives from NHS Wales bodies with civil contingency duties as Category 1 Responders under the Civil Contingencies Act 2004.

133. Category 1 responders in Wales in relation to the health care system were:

    a) A National Health Service trust established NHS (Wales) Act 2006 providing:

        i. ambulance services,

        ii. hospital accommodation and services in relation to accidents and emergencies, or

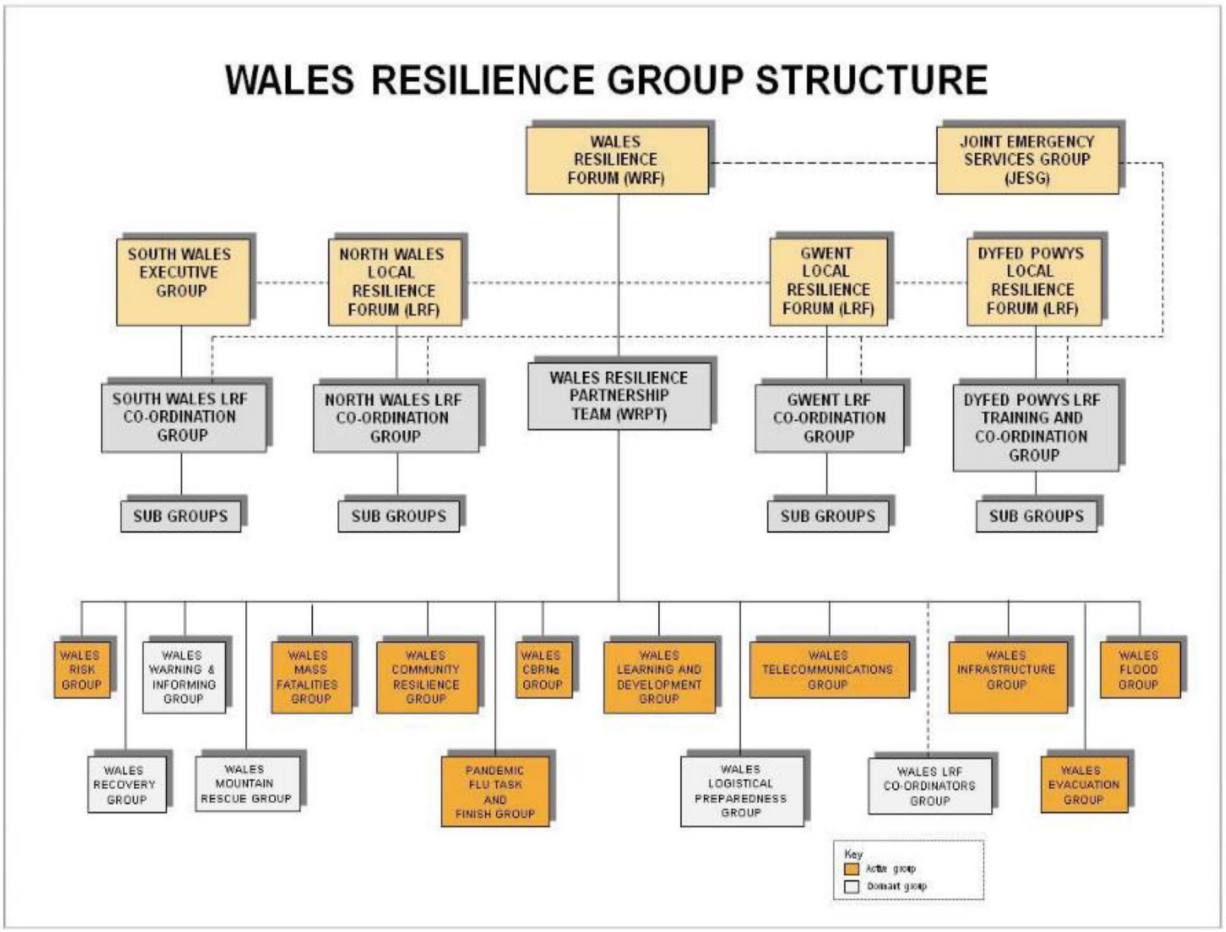
        iii. services in relation to public health.

    b) A Local Health Board established under NHS (Wales) Act 2006.

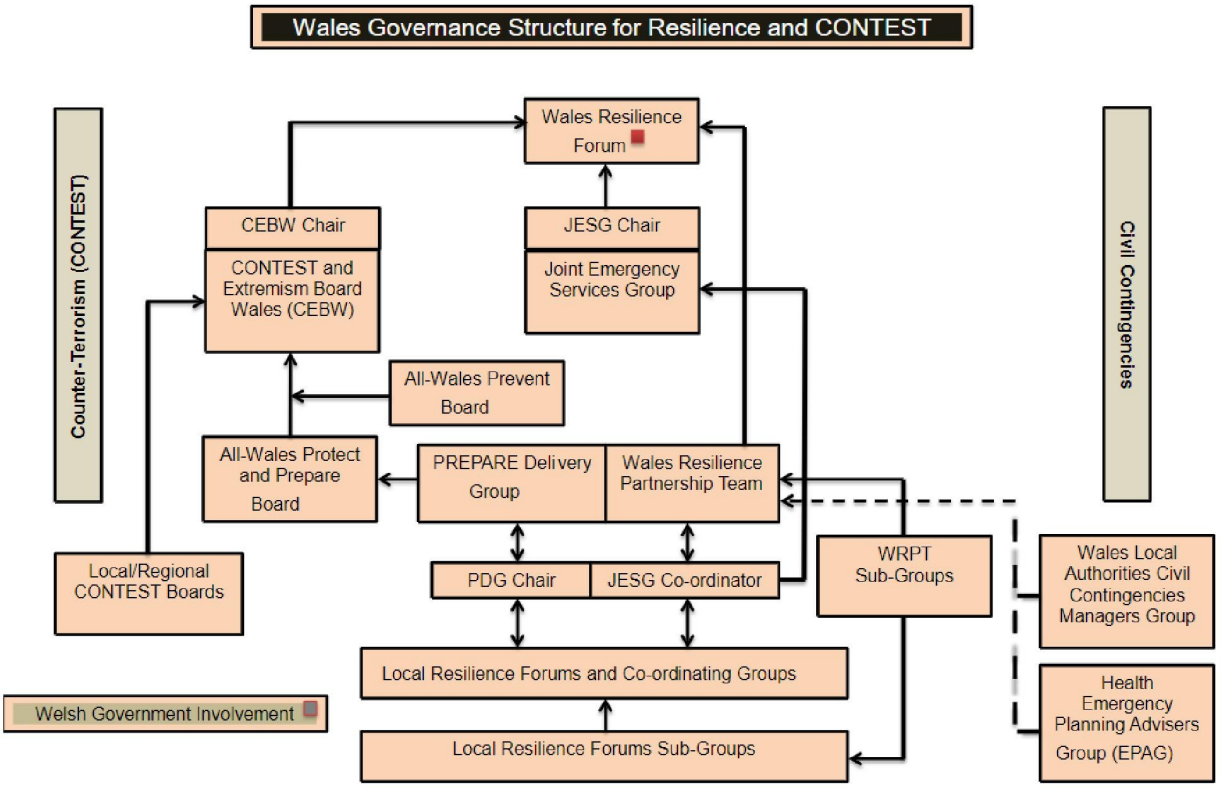
134. Category 2 Responders in Wales consisted of utilities and transport and not health services. The Health and Social Services Group is not a category 1 or 2 responder under the Civil Contingencies Act 2004. In Wales there is no central healthcare body which is a category 1 or 2 responder, such as NHS England which is a category 1 responder in England.

135. HEPU engaged internally within Health and Social Services Group and with the Minister for Health and Social Services as well as working with the UK Government Department of Health on UK-wide health emergency preparation, response and recovery ("EPRR") arrangements.

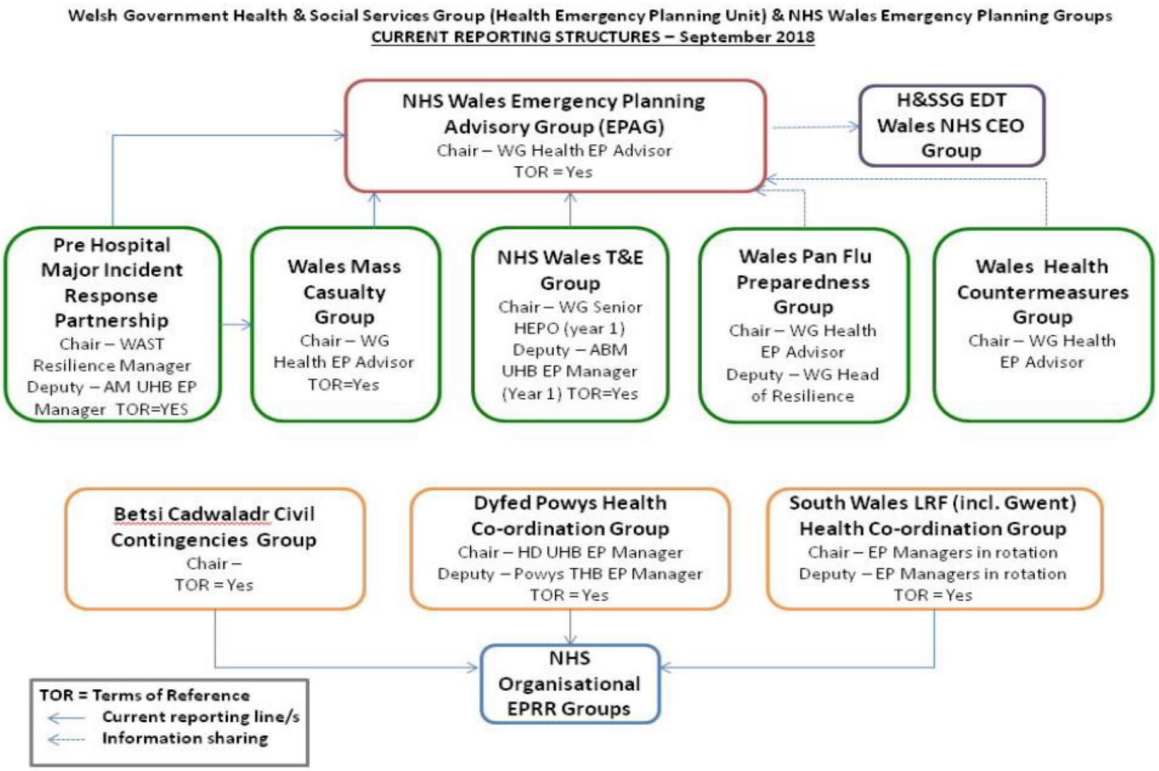
136. A health resilience paper was presented to the Health and Social Services Group Executive Directors Team and Minister for Health and Social Services in 2018 which summarises how the Health and Social Services Group positioned its health resilience functions, the structures for coordinating Wales NHS resilience activities and its approach to pandemic influenza and other emergency situations. A copy of this paper is exhibited in **AGM3WGO01/19 - INQ000116453** attached to which was a diagram of the Wales Resilience Group Structure in 2018 which is reproduced below (and exhibited in **AGM3WGO01/20 - INQ000116450**):



137. The Health and Social Services Group and NHS Wales participated in pandemic preparedness through its Wales Resilience Groups (see chart above). Both also participate in the Wales Governance Structure for Resilience and CONTEST with the Wales NHS Emergency Planning Adviser Group linked to this Structure (see chart below which is also exhibited in **AGM3WGO01/21 - INQ000116455**). The structures are headed by the Wales Resilience Forum, chaired by the First Minister. As Director General HSS I was a member of this Forum:



138. To facilitate its work, HEPU established and oversaw an NHS planning network through the Wales NHS Emergency Planning Advisory Group ("EPAG") and sub-groups to address specific requirements, which have included mass casualties, pre-hospital response requirements, health countermeasures and Wales NHS training and exercises. This national Wales NHS emergency planning structure has helped to share good practice, coordinate and support Wales NHS planning for national security risks and ensure effective and efficient NHS Wales engagement in multi-agency contingency arrangements. The reporting structure in 2018 is set out below (and exhibited in **AGM3WGO01/22 - INQ000116451**).



139. Another paper dated 23 January 2020 outlined the role of the Pandemic Flu Readiness Board ("PRFB") the action and activity in Wales at that time and therefore provides a good snapshot of the position before the Covid-19 pandemic period. A copy of this paper is exhibited in **AGM3WGO01/23- INQ000180621** which outlines how the Welsh Government sought to engage health, social services and local government in the work of the UK Board and its sub-groups. To assist in delivering outcomes of the PRFB, the Welsh Government established a Wales Pandemic Flu Preparedness Group involving representation from Welsh Government Health, Social Services, Communications, Resilience officials, Public Health Wales and the Chairs of the four Wales Local Resilience Forum Pandemic Flu Groups. Prior to the pandemic, the Group had met in November 2018 following which meetings were paused due to Brexit priorities.

140. The Welsh Government was represented on the Board and had engaged in the Sub Groups outlined below:

1. *Health Care Demand*

   A key issue during Exercise Cygnus was the surge in demand for critical care and following this exercise the draft Extreme Surge Guidance for the NHS in Wales was developed in order to support local pandemic preparedness and response planning in Health and Social Care organisations in Wales at times of extreme surge. Further detail on the guidance is set out below.

2. *Social Care Demand*

   We had a Wales representative on the sub-group and work was in place to review the Pandemic Influenza "Framework for Local Authorities and Social Services Providers" previously issued in Wales. The Wales Health and Social Care Pandemic Flu Planning and Response Guidance, agreed by Wales Directors of Social Services, required an integrated approach between these sectors in a pandemic situation. The Wales Local Resilience Forum Structure provided the basis for considering potential impacts on social care and examining the support available from other agencies. The Welsh Government pandemic health countermeasures arrangements included making these countermeasures available to front line social care staff through the local government structures.

3. *Moral and Ethical*

   The Welsh Government had nominated a Senior Medical Officer to be a member of the Moral and Ethics Group that has been established as part of the Brexit work. This Group was also expected to provide generic guidance to inform pandemic flu planning.

4. *Sector Resilience*

   The Welsh Government was engaged in the Sector Resilience Sub-Group and work had been undertaken to look at the resilience of devolved sectors to a flu pandemic. Consideration was given to the impact on staffing resources and the delivery of services that a pandemic outbreak could entail to provide Ministerial assurance. Welsh Government Departments were asked to provide information on the work being undertaken specifically in the education, transport, water, fire, health, and central and local government sectors and responses were

considered. In terms of health engagement, all the NHS Wales organisations were consulted on their business continuity arrangements. These arrangements built on a range of UK wide health measures that support NHS resilience, including NHS clinical networks and mutual aid, health counter measures that help protect NHS staff and the National Pandemic Flu Service, which is a contingency that would protect front line primary care services. In terms of local government engagement, the Welsh Government attended a Welsh Local Authorities Civil Contingencies Manager's Group meeting to discuss pandemic flu preparedness in all 22 local authority areas.

5. *Cross-Cutting Enablers (Legislative Vehicles)*

During Exercise Cygnus, the Welsh Government worked with the Cabinet Office in identifying devolved and reserved areas of legislative asks. As part of this review, officials are fully involved in the work to establish a four nation draft Pandemic Influenza (Emergency) Bill that would be readily available to pass into law in the event of a pandemic.

6. *Excess Deaths*

The lowering of the target capacity on excess deaths following Swine Flu to a range between 0.35% and 0.525% of the population allowed local planners to calculate the likely impact in their areas and they had generally concluded that the funeral industry will be flexible enough to cope. To supplement this, there are arrangements in place to increase crematoria capacity to deal with excess numbers and other plans in place to make the process more effective.

7. *Communications*

The Welsh Government Communications Division was engaged in the work being undertaken at the UK level to revise the UK Communications Plan in the light of the findings of Exercise Cygnus. Information relating to Wales in this plan was updated rather than developing a separate plan. Public Health Wales was engaged in this work in relation to confirming the point of contact for communications is still the same, the various responsibilities relating to communications and designated spokespeople. Further consultation was intended with the local health board

Heads of Communications, Welsh Government Press Office, Chief Medical Officer and the Chief Executive of NHS Wales. One challenge considered in Wales is the need to translate the public information and key messages which have to be available bilingually.

141. As this paper outlined there was active work underway to develop or update plans for dealing with an influenza pandemic. Each NHS body in Wales had its own local pandemic and business continuity plan and all Local Resilience Forums had multi-agency pandemic plans for their area.

142. In Wales there was no equivalent to the NHS England emergency preparedness, resilience, and response (EPRR) framework. The national plans and guidance in place prior to the pandemic period, as agreed to by HEPU and/or EPAG are listed in exhibit **AGM3WGO01/24 - INQ000227404** and have been provided to the Inquiry already as part of Module 1. Of particular note are the following which are relevant to the issues in Module 3.

143. *The UK Pandemic Influenza Strategy 2011* (exhibited in **AGM3WGO01/25 - INQ000177116**) – This strategy was agreed by the health ministers in all four nations and set out the planning assumptions that would apply, strategic objectives and matters of policy but did not include any detail about a Wale-specific plan.

144. *The Pan-Wales Operational Response Plan (2019)* (exhibited in **AGM3WGO01/26 - INQ000089571**[30]) outlined oversight arrangements in an emergency pandemic situation including the expected roles of the Welsh Government, ministers and NHS in Wales[31]. This also detailed the standing up of the Emergency Co-ordination Centre Wales ("ECC(W)")[32] to gather and disseminate information across Wales and the establishment of a Wales Civil Contingencies Committee ("WCCC")[33] to have oversight and responsibility for advising on, among other things, identification of areas of need and deployment of scarce resources across Wales. This Plan also confirmed that the local response is the building block of resilience and set out the expectations for a local response to include considered of, among other things, protecting the health

[30] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000107119]
[31] Section 5 of the Pan-Wales Response Plan AGM3WGO01/26 - INQ000089571
[32] Section 3 of the Pan-Wales Response Plan AGM3WGO01/26 - INQ000089571
[33] Section 2 of the Pan-Wales Response Plan AGM3WGO01/26 - INQ000089571

and safety of all personnel, maintaining, or restoring critical services and maintaining normal services at an appropriate level[34].

145. *The Wales Health and Social Care Influenza Pandemic Preparedness and Response Guidance* issued in February 2014 (exhibited in **AGM3WGO01/27 - INQ000116503**) was a significant document as it formed the basis of the later, Covid-19 specific Health and Social Services Group Covid-19 Planning and Response Systems Framework, which I will refer to later in this statement.

a) **Wales Ambulance Service-** Even in the event of a low impact pandemic it was anticipated that there may be a significant increase in ambulance call rates, which will need to be managed. The Resourcing Escalatory Action Plan used by ambulance services at all times is designed to increase operational resources in line with demand, to cope with periods of high pressure and maintain the highest quality patient care. If operational, the Guidance expected the National Pandemic Flu Service (NPFS) and/or the pandemic influenza advice line, together with NHS Direct Wales may mitigate some of the pressure on the ambulance service. Rapid handover at hospitals was thought to be critical in making best use of ambulance time and ensuring maximum availability of beds.[35]

b) **Primary Care-** During the initial response in the detection and assessment phases in a pandemic the Guidance recognised that primary care services would come under pressure and need to implement escalation plans where there were concentrated levels of activity or hotspots. Once a pandemic moved to the treatment and escalation phases the pressure on and plans for primary and community care would depend on whether the pandemic was low impact, moderate impact, or high level. As well as maintaining essential provision for non-influenza patients, the resources and skills available in GP practices would focus primarily on patients who were suffering influenza complications, less than five years of age, pregnant, have relevant pre-existing medical conditions, are in a clinical 'at-risk' group, are not responding to treatment, need higher levels of care

[34] Section 8 of the Pan-Wales Response Plan AGM3WGO01/26 - INQ000089571
[35] P29 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503

but are unable to be admitted to hospital, require symptom control or end of life care or need bereavement support.[36]

c) **Secondary Care**- As with primary care, the effect on secondary care would depend upon whether the pandemic was low impact, moderate impact, or high impact. For low impact pandemics the guidance foresaw no significant deferral of normal activities, save that some specialist services may come under pressure, for example critical care and emergency departments. The Guidance noted that it is essential, in order to prepare for a moderate or high impact pandemic, for continuity arrangements for staff and supplies to be in place as well as careful consideration to be given to planning for the necessary reductions in non-critical work. Specifically moderate impact pandemic hospitals were required to respond to increasing referrals of respiratory patients requiring higher level of care by prioritising in and outpatient resources to enable the maximum number of beds to be available. In high impact pandemic hospitals difficulties may be exacerbated by staff absences so it would be essential to use staff flexibly.[37]

d) **Critical Care Services**- critical care services utilised at a high bed occupancy rate of around 98-100% and were likely to come under significant pressure even in an early stage or low-impact pandemic. A prompt and flexible response to manage and match increased demand.[38] As a result of the swine flu pandemic measures were developed to expand the capacity of intensive care services including identifying potential extra bed capacity in related areas such as operating theatre recovery suites, step-down and high dependency care facilities; maximising the use of stockpiled equipment; broadening the training of staff who could support these beds to increased available staff numbers; supporting more formal cross-training and experience between adult and paediatric services to increase the ability to provide more flexible and overlapping services; supporting the specialist staff who would have to manage the triage, admission and discharge of patients; supporting accurate and timely data on critical care capacity; supporting collaborative working to provide mutual aid.

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[36] P27-28 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[37] P35 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[38] P 36 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503

e) **Vulnerable groups**- The Guidance recognised the importance that Health and Social Care organisations have continuity plans in place to maintain services for those who are already known to be in vulnerable groups. Local authorities and NHS organisations should have systems in place so that during the pandemic they are able to establish quickly and accurately which additional individuals and groups are vulnerable and the reasons for this.

f) **Allocation of staff and staff welfare**[39]- The Guidance emphasised that flexible planning was necessary to make best combined use of staff skills and competencies may enable better quality of services to be maintained, even if high sickness absence levels occur during moderate or severe pandemics.

i. For example:

1. Pharmacist and nurse prescribers could play an important role in prescribing medicines for those who cannot access their usual prescriber.

2. In hospitals, clinical pharmacists could play a role in supporting other clinicians in areas such as adult and paediatric intensive care units.

3. Voluntary and community organisations could offer a wide range of skills and specific contributions including providing social support, assisting those experiencing stress, anxiety and grief; staffing help lines or acting as 'flu friends'.

4. There may be opportunities to use the assessment and treatment skills of dental practitioners or other health professionals to support the wider deliver of health care in a pandemic.

5. A helpline for staff was noted to be potentially useful.

ii. In the interests of staff welfare, the Guidance considered it helpful to note:

[39] Page 17 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503

1. Whether they have dependents (as they are more likely to need care leave).

2. Whether they have underlying conditions, or are pregnant, and may therefore be at increased risk from influenza.

3. Where they live and how they usually travel to work as this would help with planning if transport was disrupted.

iii. It was noted to be important to ensure that normal working patterns in a pandemic must include adequate time off work to prevent absence due to exhaustion or stress caused by pressure over a sustained period of the cumulative impact of the emergency such as bereavement, additional care responsibilities or ill health.

iv. It was envisaged that once a pandemic vaccine became available it would be important to encourage uptake by frontline health and social care staff in order to protect them, their patients, clients, families and colleagues and in improving the resilience of the services they provide.

g) **Resource allocation**- An ethical framework was developed by the Committee on Ethical Aspects of Pandemic Influenza in 2007 to ensure that ethical considerations are applied in determining how to make the fairest use of resources and capacity.[40]

h) **PPE**- Surgical facemasks and respirators play a role in providing healthcare worker protection. Fluid repellent surgical masks should be worn by health and social care workers for any close contact with patients (i.e. within one metre) with symptoms of influenza.[41] The Guidance noted that there were national stockpiles of facemasks and antiviral medicines but it could take a few days for distribution of centrally held stocks to the local health boards/trusts. Normal NHS supply chains would not be used for items in the national stockpile. Rapid dispersal of supplies from national stocks depends upon having a limited number of delivery points and local plans are required for delivery points, suitable storage, record keeping and

[40] Pages 13 and 50 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[41] Page 50 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503

management of stocks, and for receiving deliveries at short notice, possibly outside normal working hours.[42] Organisations should maintain sufficient stock for seven days use in the initial stages of any pandemic.[43] At the time the recommended respirator was FFP3 and it was held in the UK stockpile in the event of a pandemic. They should be worn when performing procedures that have the potential to generate infectious aerosols such as intubation, extubation and bronchoscopy. At the time there was very little evidence of widespread benefit from the use of facemasks in the community and so the Government would not be stockpiling facemasks for general use in the community.

i) **Business continuity and maintaining essential services**[44]- Health and Social Care providers are required to have robust and tested business continuity plans in place to help ensure continuation of services, specifically addressing the potential effect of staff absenteeism, which should include mutual aid and/or shared agreements to support service delivery and to sustain an integrated response.[45]For normal and out of hours services (including pharmacies), arrangements were required for collaboration, "buddying" or other support at times of increased pressure to ensure continuity of services for those that need them most.[46] Assurance of sufficient supplies required a detailed understanding of the potential impact of a pandemic on the supply of consumables, medicines and other services that are critical to maintaining necessary services. Organisations were asked to ensure that their suppliers had a business continuity plan in place that was resilient to the potential supply chain challenges they may face in a pandemic.[47]

j) **Testing**- During the initial response in the detection and assessment phases the Guidance set out that all patients presenting with influenza like illness will need to be tested via respiratory swab to enable rapid identification of the virus strain and spread. In order to reduce pressure in other areas in the NHS it would be

[42] Page 23 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[43] P50 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[44] Page 15 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[45] Page 16 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[46] Page 9 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503
[47] Page 16 of the Preparedness and Response Guide AGM3WGO01/27 - INQ000116503

appropriate to use an appropriate skill mix of NHS staff, including in primary care, to undertake this testing.

146. *Pandemic Influenza: Extreme Surge Guidance for the NHS in Wales* (exhibited in **AGM3WGO01/28 - INQ000252542**) was in draft form at the start of the pandemic having been last reviewed in February 2020 and intended to be annexed to the Wales Health and Social Services Pandemic Planning and Response Guidance exhibited above. This document, as drafted for pandemic influenza, was not used in that form during the Covid-19 pandemic. It was however updated for Covid-19 by the Covid-19 Health and Social Services Planning and Response Group in April 2020, as exhibited in **AGM3WGO01/29 - INQ000253848**[48]**.** This guidance was drafted as a contingency and never needed to be implemented during the pandemic period.

a) **Critical care capacity**- It was anticipated that critical care capacity to be increased during a pandemic to care for increased numbers of patients with respiratory conditions or whose underlying conditions were affected by Covid-19.

i. The following principles fell to be considered:

1. critical care would be preferentially provided for individuals considered most likely to benefit,

2. patients with an equal chance of benefitting from critical care should have an equal chance of receiving it and triage/treatment decisions would be made on a rational,

3. non-arbitrary basis supported by objective evidence.

ii. During a severe pandemic it was anticipated that there may be ten times as many patients requiring mechanical ventilator support as number of beds available. To increase capacity in critical care for mechanical ventilation, the following sequential temporary cancellation of all elective surgery likely to require post-operative adult critical care support may be necessary:

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

4. All elective non-life-threatening surgery (with the exception of major oncology, cardiothoracic vascular and neurosurgery);

5. All elective non-life-threatening neuro, vascular and cardiothoracic surgery;

6. All elective surgery including major oncology, cardiothoracic, vascular and neurosurgery.

iii. To release ward beds and theatre space to allow further critical care surge capacity it may be necessary to:

7. Ventilate outside critical care facilities;

8. Cancel all non-life-threatening surgery regardless of requirement for critical care.

iv. The admission and discharge from critical care, in addition to being a peer consensus decision, could be informed by the Canadian triage model which uses Sequential Organ Failure Assessment organ scoring combined with an exclusion criteria.

v. A decision may be taken by NHS Wales to cease all critical care activity, which would be for the shortest period possible and would enable re-distribution of resources.

b) **Identification and prioritisation of areas of most need**- the guidance noted that the NHS is not uniformly structured and that there are local variations according to the need of patients. For that reason, the guidance expected local decisions to be made in the initial stages of a pandemic about the suspension of some clinical activity to allow others to continue or increase.[49]

c) **Allocation of resources**- treatment priorities were to be set by a clinical selection process taking into account ethical principles and assessment of the patient's need for the resource, potential to return to their baseline health state, overall resource

[49] Page 6 of the Extreme Surge Guidance AGM3WGO01/28 - INQ000252542

needs, and underlying health conditions and prognosis relating to the underlying disease.

i. There was no single, cross-specialty, objective scoring system to generate a score to guide exclusion from admission or service access.[50]

ii. Any decision to admit, refuse or withdraw treatment, influenced by factors other than the patient's best interest required peer consensus between two clinicians of sufficient seniority and expertise.

iii. Each provider of NHS funded care was required to put in place a suitable clinical governance system to make timely decisions regarding clinical resource allocation, for example through the use of triage teams.[51] This requirement was also set out in the subsequent iterations of the guidance for Covid-19 in April 2020, January 2021 and December 2022 though, as indicated below, this guidance was never implemented.

iv. Acute hospital care, including surgery and non-surgical interventions, would only be undertaken where the clinical assessment suggests the patient has a reasonable chance of survival, and at least 25% increase in the likelihood of survival by receiving that treatment. In the event that two critically ill patients were assessed as having equal survival chances and were competing for one acute bed, the guidance required decisions to be made on a 'first come' basis. However, if a new arrival had a greater chance of survival than an existing patient, it was envisaged that the existing patient would be provided appropriate supportive or end of life care.

d) **Discharge strategies-** A range of discharge strategies, together with mitigating actions, may be required to allow for prompt discharge from high-level resource facilities. This would require effective multi-agency communication involving senior clinicians and managers across primary, acute and social care systems.

147. The Extreme Surge Guidance was revised several times at points of significant operational pressures during the course of the pandemic, firstly, in January 2021,

[50] Page 10 of the Extreme Surge Guidance AGM3WGO01/28 - INQ000252542
[51] Page 10 of the Extreme Surge Guidance AGM3WGO01/28 - INQ000252542

entitled "COVID-19 managing extreme surge in Wales NHS, exhibited **AGM3WGO01/30 - INQ000299731;** and December 2022, entitled, "Guidance to Support Wales NHS Response to Extreme Pressure / Surge, exhibited **AGM3WGO01/31- INQ000300254.** The guidance was prepared with input from the Moral and Ethical Advisory Group, legal services and NHS Wales Medical Directors. It was, however, never implemented. I believe this was a direct result of the impact of the other mitigating actions put in place before it. The extreme surge guidance was always considered as an action of last resort as it would have been required had the health and social care system ever become overwhelmed, reaching the point where demand for services had outstripped the resources available.

148. The *All-Wales Critical Care Escalation Guidance* dated October 2016 (exhibited in **AGM3WGO01/32 - INQ000226913**) which outlined the expectation for local health boards and NHS Trusts, where appropriate, to work with the critical care and trauma network, Welsh Health Specialised Services Committee ("WHSSC") and each other to ensure arrangements for critical care escalation for management of a large unplanned increase in demand were in place.

149. The *Wales Framework for Managing Major Infectious Disease Emergencies* issued in October 2014 (exhibited in **AGM3WGO01/33 - INQ000226910**) provided generic guidance for the co-ordination and management of major infectious disease emergencies and a framework in which detailed operational planning for specific diseases could be undertaken. This Framework included guidance on laboratory testing facilities and management of initial cases. It also outlined the requirement that Public Health Wales, hospitals and primary care services should maintain a stock of FFP3 respirators and facemasks and arrangements for distribution of additional stock in an emergency. The Framework did not specify how much stock was required. The Framework also outlined the requirement for bodies to have business continuity plans in place and local plans for ensuring essential services were maintained and resources were used effectively. The Framework also outlined key roles and responsibilities for various organisations in Wales including that of Welsh Ambulance NHS Trust in respect of ambulance services and NHS Direct in respect of information and support to the public via NHS 111.

150. These plans were expanded on and developed to meet the unprecedented impact of the Covid-19 pandemic which I will touch on below and explore and in more detail in later in this statement.

The Covid-19 pandemic period

151. As noted above there was no equivalent EPRR framework to the one that applied in NHS England. The Pan Wales Response Plan requires that a responsibility for declaring an emergency was a decision to be taken by the Welsh Government in conjunction with the UK Government and Category 1 or 2 responders (as defined in the Civil Contingencies Act 2004). At the start of the pandemic the four nations were working on a public health response specific to Covid-19, as opposed to a civil contingencies response so such a declaration was not made.

152. Although no formal direction was issued to NHS bodies to utilise the pre-pandemic emergency plans, we used the existing plans as the basis for our emergency planning response, and we did follow the preparation phases of the Pan Wales Response Plan, which required us to track and monitor the public health developments. While I do not recall us specifically deciding to formally trigger the Pan Wales Response Plan, this plan did inform and form the basis of much of our action during this initial phase.

153. Directions were issued to NHS bodies on how to plan and prepare for the pandemic in the form of Quarterly Frameworks and supporting guidance as outlined in detail in this statement. At no point did the Welsh Government or any other central organisation in Wales assume central 'control and command' of the healthcare system's response. Local health boards retained local responsibility for the delivery of services and to the response to the pandemic but were supported by the Welsh Government which also monitored NHS activity alongside NHS capacity to ensure the NHS was not overwhelmed.

154. The *Covid-19 RWCS* (reasonable worst case scenario) *Planning Base Parameters,* compiled by SAGE and the Civil Contingencies Secretariat, set out the technical and clinical assumptions for the Government's response planning. As of 13 February 2020 (exhibited in **AGM3WGO01/34 - INQ000210803),** this indicated that:

a) There was evidence of human-to-human transmission within close groups outside China, but there was not currently evidence of sustained human-to-human transmission i.e. across communities outside of China, but this eventuality could not be ruled out.

b) Expert modelling for the UK indicated that an epidemic would be expected to peak 2 to 3 months from the onset of established human-to-human transmission in the UK.

c) SAGE advice was that up to 80% of the population may be infected, however not all of these would experience symptoms and the vast majority of cases will be mild disease. The planning assumption was that 2 – 3% of symptomatic cases would result in a fatality, though this number would likely go down as scientific understanding improved.

d) It was considered likely that a mildly symptomatic person could transmit the virus. Current evidence could not rule out transmission by a totally asymptomatic person.

e) The extent of workforce absences was currently unknown and SAGE advised use of the pandemic flu reasonable worst case planning assumptions as a guide: 17-20% absences in peak weeks, 50% of the workforce may require time off at some stage during the whole pandemic.

f) Pandemic flu planning assumptions were also advised in relation to possible numbers requiring assessment by the health service: of symptomatic persons 30% would require assessment, 4% would require hospital care and 1% the highest level of critical care.

155. In February 2020, the working assumption for plans and system actions was therefore that the pandemic would last a short intense period with a peak between 2 to 3 months from the onset of sustained human-to-human transmission in the UK, that would need urgent action to mitigate the expected impact on the population and services. However, the reality was the pandemic lasted far longer than we had originally anticipated.

Guidance and plans issued to the healthcare system

156. The long duration of the pandemic required the Welsh Government's Health and Social Services Group to learn rapidly from its experiences to adapt and to improve its response. In terms of the Welsh Government's plans and guidance for the healthcare system to deal with a pandemic I have outlined above those in place before the pandemic period which touch on the issues brought out by Covid-19 which are the subject of this module of the Inquiry. These plans and guidance changed and developed during the pandemic period to react to the science and learning coming out at the time. A full list of all the guidance issued during the pandemic is exhibited in **AGM3WGO01/35 - INQ000227428.** Those which fall within the scope of Module 3 have been set out in **Annex 2** for ease of reference.

157. In terms of how those plans changed and/or developed between 1 March 2020 and 28 June 2022 and the reasons for those changes I will set this out in detail in later in this statement in the context of the specific subject areas.

Communication and dissemination of information, policies, and guidance to the healthcare system

158. The proximity of relationships across NHS organisations and partnership arrangements with social care and wider stakeholders assisted regular communications and collaborative decision making. I believe this was a major contributing factor to the effectiveness of the response across health and social care in Wales. This includes the direct contact I had with NHS chief executives and senior NHS representatives to inform and receive decisions; which meant that many of our central decisions were jointly owned by the NHS bodies in Wales and had the necessary momentum as we looked to implement urgently in a highly pressured environment.

159. Whilst the Health and Social Services Group and the wider Welsh Government is compact in size, rather than a constraint, I think this opens up a more open and collaborative leadership approach with the NHS in Wales, and more broadly with other agencies and stakeholders also – and we used that absolutely to our advantage during the pandemic response.

160. During the relevant period the Health and Social Services Group met frequently with NHS leaders through the Health and Social Services Planning and Response Group

and its sub-groups. We deliberately included NHS leaders in the membership and to act as co-chairs of the sub-groups to ensure swift dissemination of information, policies and guidance to the health care system.

161. In order to transmit emergency alerts we had a system which Public Health Wales oversaw to disseminate public health links or Chief Medical Officer links to the system quickly as well. The Chief Medical Officer has provided a list of all public health links for the period in his evidence submitted referenced M3-CMO-01.

162. Communication to frontline health care workers was via the health board leadership. NHS Chief Executives, Medical Directors and Nurse Directors were in regular contact with myself, Chief Medical Officer and Chief Nursing Officer throughout the relevant period to facilitate this.

163. The Chief Medical Officer and Chief Nursing Officer had significant autonomy and were able to make and implement system decisions as the professional leads for NHS Wales. On occasion, when the additional authority that came from my role as Chief Executive NHS Wales was needed, I would also correspond with the chief executives of the bodies that comprised NHS Wales, on specific requirements and policy decisions. The Chief Medical Officer, Chief Nursing Officer and I would liaise closely at these times and coordinate our communications for the purpose of clarity and consistency.

164. There was inevitably a need for the Welsh Government and Public Health Wales to closely coordinate their activities, and their communications, but to the best of my recollection this worked well, and I know that colleagues within the Health and Social Services Group and Public Health Wales were in regular contact to ensure clear and consistent messaging for the health care system and the public. Public Health Wales also helped inform and guide our learning throughout the pandemic.

Changes to structures and processes for Health and Social Services Group and NHS in Wales

165. The structures and response were not static and the Health and Social Services Group structure, role and functions were continually evolving throughout the specified period to accommodate the new Covid-19 specific areas of work. A number of new sub-teams

were created within divisions and personnel re-deployed both within the Health and Social Services Group and from other Welsh Government directorates.

166. As the pandemic emerged in January and February of 2020, the Welsh Government's response was initially managed by the Minister for Health and Social Services who was supported by officials from the Health and Social Services Group with responsibility for emergency health planning, working closely with Public Health Wales NHS Trust ("Public Health Wales").

167. Organograms representing the organisational structure in the Welsh Government at significant points before and during the pandemic period are provided in this statement:

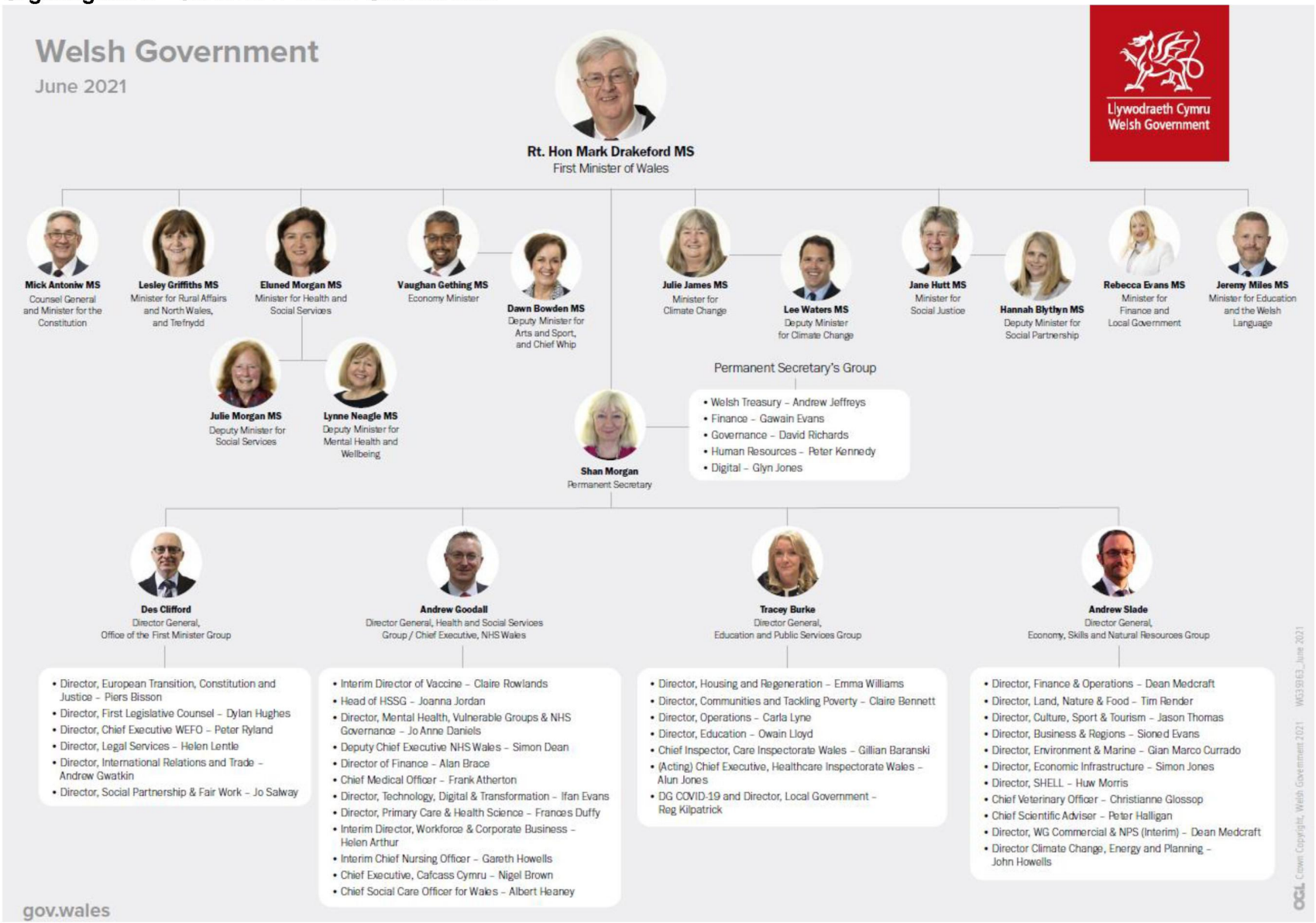
    a) The structure in November 2019, representative of the structure in advance of the pandemic, is set out in Organogram 1 in paragraph 50 above.

    b) In Organogram 2 dated *January 2021* and Organogram 3 dated *June 2021* below, the structural changes which took account of the pandemic are set out – including the introduction of the role of Deputy Director General for Health and Social Services Group, Head of Health and Social Services Group, and Director of Vaccines. This also sets out the role of Reg Kilpatrick who was Director General of Covid-19 Coordination and Director of Local Government with responsibility for the Covid-19 project team. Although not set out, in this period Jo-Anne Daniels transitioned to being Director for Test, Trace, Protect ("TTP").

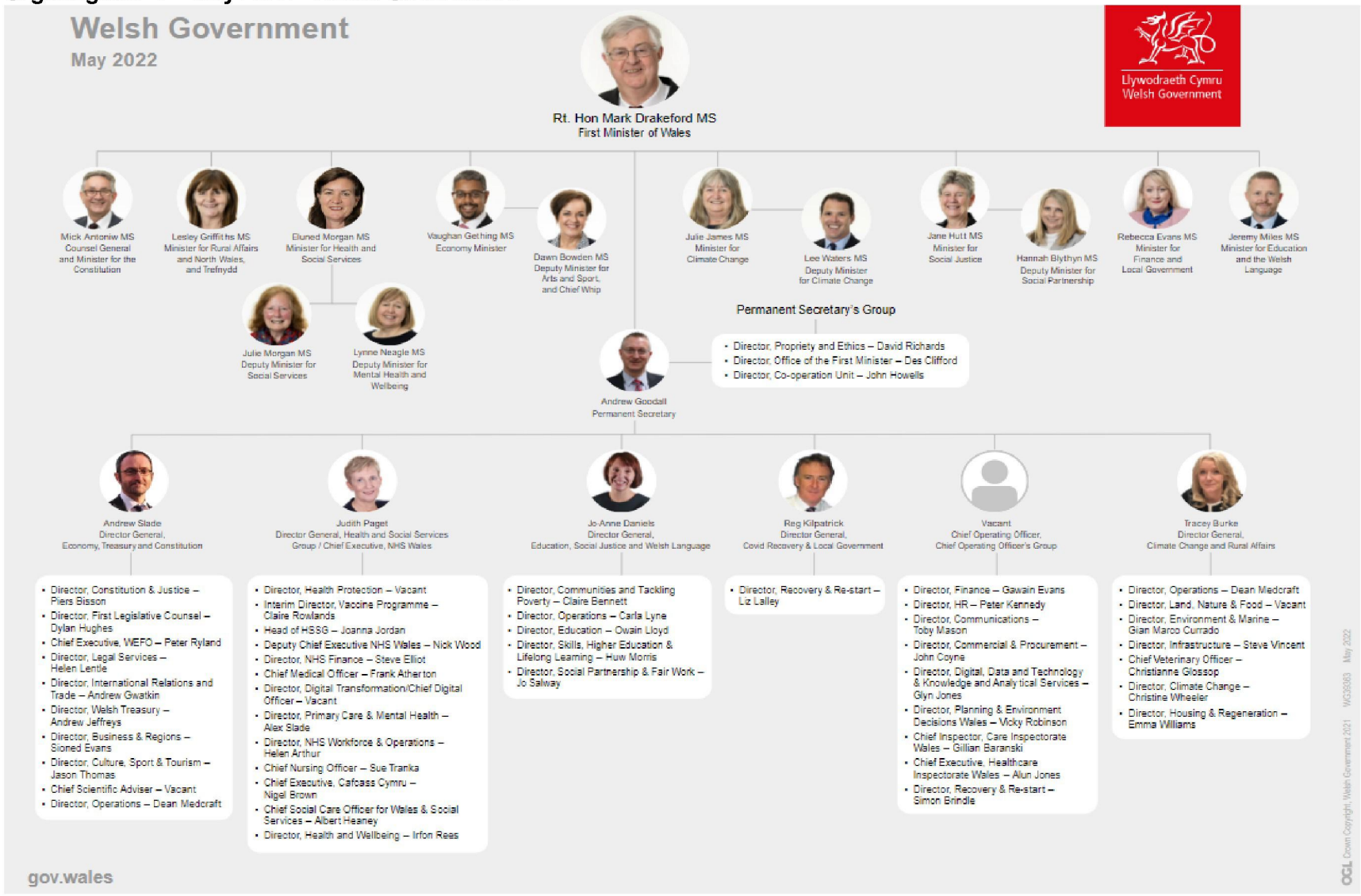
    c) Organogram 4 below, dated *May 2022*, highlights the change of Permanent Secretary to me from November 2021 and the resulting change of the Director General of the Health and Social Services Group to Judith Paget in November 2021.

Organogram 2 – January 2021 Welsh Government

Organogram 3 – June 2021 Welsh Government



Organogram 4 – May 2022 Welsh Government



168. Only the Health and Social Services Group officials at Director level are outlined in the organograms for 2019 – 2021. I have however listed in **Annex 1** to this Statement[52] the key senior civil servants related to the Covid-19 response working within Health and Social Services Group. This is not an exhaustive list and the Health and Social Services Group worked closely with a number of other directorates throughout the pandemic period and particularly with the Covid-19 project team led by Reg Kilpatrick to support the provision of advice to Ministers on a range of issues relating to the functions Health and Social Services Group oversaw, including on non-pharmaceutical interventions.

169. In addition to the key officials in Health and Social Services Group outlined above, we also introduced Senior Military Liaison Officers into the Health and Social Services Group to assist with NHS planning, and who were ultimately distributed across the NHS in Wales in support roles ranging from planning to field hospital establishment and the operation of vaccination centres. This was delivered through a mix of discretionary support discharged through Military Aid to Civil Authorities ("MACA") arrangements. The Military involvement started very early in in our planning and preparation phase and acted as planning support, logistics advice, operational support for establishment and a reference point for capacity planning and urgent actions and were very welcome as part of the broader Health and Social Services Group and NHS team.

Health and Social Services Planning and Response Group

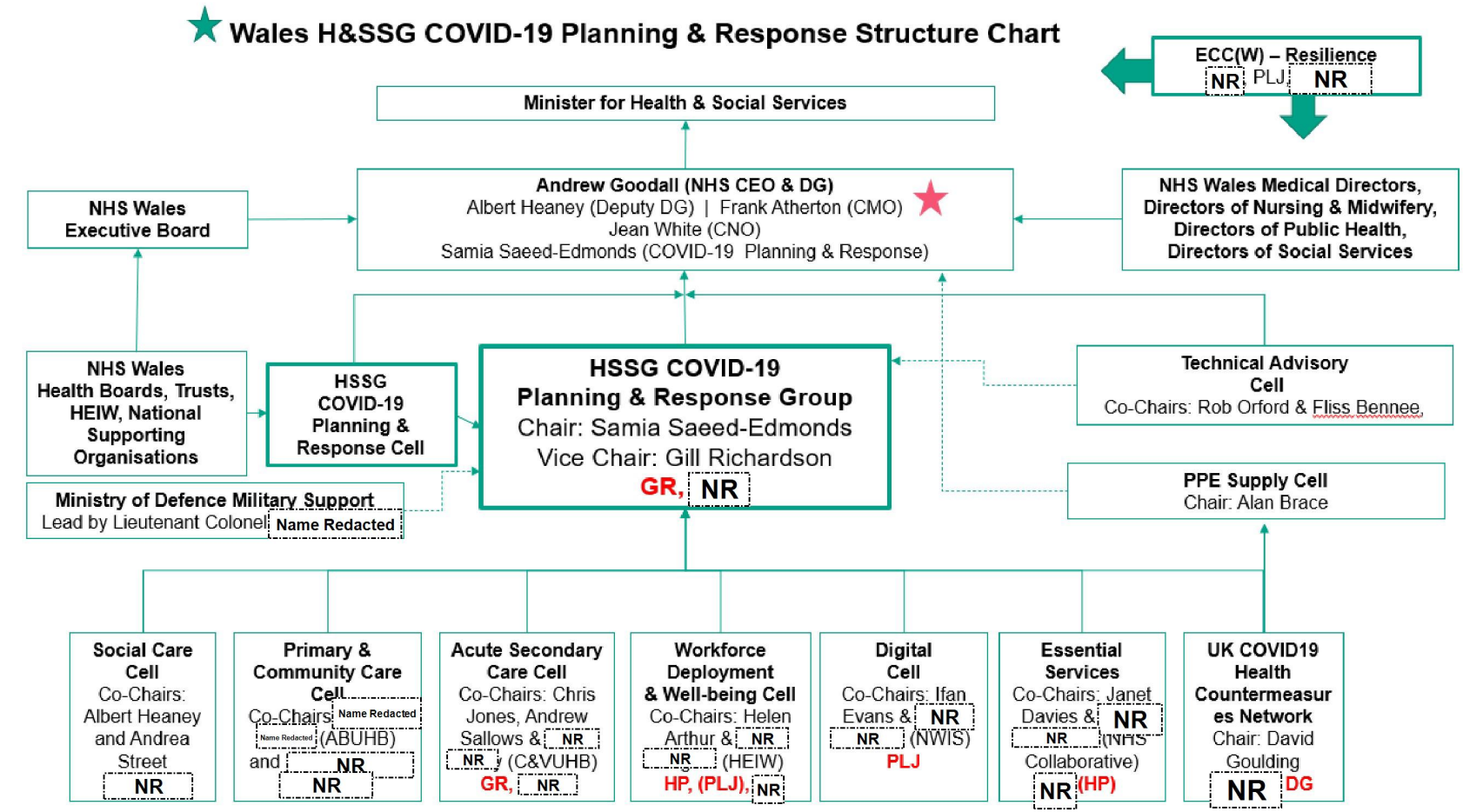
170. I established in February 2020, the Health and Social Services Group Coronavirus Planning and Response Group ("Covid-19 Planning and Response Group") which was chaired by Samia Edmonds and vice-chaired by Gillian Richardson, Senior Professional Advisor to the Chief Medical Officer for Wales ("CMO(W)"). This group reported to me and Frank Atherton, CMO(W). The Covid-19 Planning and Response Group brought together strategic representatives of the Health and Social Services

[52] This includes all employee types in a Senior Civil Service (SCS) or Special Advisers (SPA) graded post during the period 31 January 2020 to 30 May 2022. Multiple lines for individuals are shown where organisational structures/roles changed during the period. Where an until date is not shown, this was a current role at the time data was accessed from the live HR system on 20 Jan 2023.

Group, NHS Wales, and social care. Its role was to consider the latest Reasonable Worst-Case Scenarios ("RWCs") for Covid-19 risk assessment, co-ordinate contingency response planning across Health and Social Services Group, share information and communications to raise awareness on contingency arrangements and actions and provide a strategic interface for health, social care services and Welsh Government Health and Social Services Group officials.

171. The diagram below outlines the structure of the Covid-19 Planning and Response Group and its links to the wider organisation and externally.

Organogram 5 – Health and Social Services Planning and Response Structure



172. The first meeting of the Covid-19 Planning and Response Group was held on 20 February 2020. Each of the health boards provided a key issue update for their area covering NHS and care services enabling Health and Social Services Group officials to have a good understanding of preparedness, system risks and issues, which included discussion on PPE supplies and guidance preparation. The Covid-19 Planning and Response Group remained active throughout the whole of the specified period. It was a structure that provided a lot of valuable intelligence.

173. At each meeting of the Covid-19 Planning and Response Group updates would be provided on

a) Communications

b) Risk Assessment & Planning Assumptions from the Chief Scientific Adviser

c) Public Health Wales Operations update

d) Update on Guidance

e) Updates from all the sub-groups which were part of the Covid-19 Planning and Response Group

f) Organisations updates from members

174. By way of example, I exhibit the agenda and minutes for the following meetings to demonstrate the intelligence that was provided at these meetings. The meeting minutes were later replaced with action notes.

Date	Agenda	Minutes /Action note
27 March 2020	**AGM3WGO01/36 - INQ000309970**	**AGM3WGO01/37 - INQ000310039**
14 April 2020	**AGM3WGO01/38 - INQ000310049**	**AGM3WGO01/39 - INQ000310054**
19 May 2020	**AGM3WGO01/40 - INQ000310136**	**AGM3WGO01/41 - INQ000312483**
23 June 2020	**AGM3WGO01/42- INQ000310224**	**AGM3WGO01/43 - INQ000312489**

175. The above documents provide examples of the practical ways information was used to progress the Covid-19 healthcare response, included extending an invitation to the group to join the modelling forum which sat under the Technical Advisory Group, issues relating to communications, information regarding blister pack shortages in pharmacies, sharing of guidance, information on the work around application of guidance in relation to those with learning disabilities, and thermometer stock levels.

176. As soon as significant risks emerged that required more dedicated input, I ensured that specific Cells were added on to the structure. It acted to share experiences and assessment in collaboration with the healthcare system and to ensure proposed actions were as informed as possible.

177. There were seven sub-groups of the Covid-19 Planning and Response Group established to co-ordinate action and manage systems risks across a number of areas. Similarly, these ensured a collaborative approach across Welsh Government and healthcare system representatives. The sub-groups covered the following areas:

Primary & Community Care

178. The Co-Chairs of this group were Dr Name Redacted Professional Medical Advisor, Primary Care and Name Redacted Nursing Officer, Primary and Community Care, Integration and Innovation.

179. The group co-ordinated Covid-19 planning and response across the primary and community care sectors, including for the reasonable worst-case scenarios. The sub-group provided the point of contact and communications with those sectors during the Covid-19 pandemic. The sub-group's focus was to share national information, including latest risk assessment and advice; examine and seek to address sector concerns; clarify and set out key planning and response structures; identify appropriate contingency measures going forward; and advise on strategic operational response requirements.

Acute Secondary Care

180. Co-Chairs of this group were Dr Chris Jones, Deputy Chief Medical Officer, Andrew Sallows, Delivery Programme Director and Steve Curry, Chief Operating officer, Cardiff and Vale University Health Board. The group provided leadership and oversight in relation to services normally provided in hospital settings. The aim of the group's work was to free up as much capacity as possible in hospitals for those patients most severely affected by Covid-19 as well as maintaining services for other people with life threatening conditions. The group supported the NHS in Wales in its preparations across a number of pathways, including consideration of whether and how certain patients could be managed at home, what criteria should be used to decide whether people should be admitted to hospital, and what treatment would be provided.

Social Care

181. The Social Care subgroup was co-chaired by Albert Heaney, Director of Social Services and Integration and Andrea Street, Deputy Director Social Services and Integration and consisted of vital stakeholders from across the social care sector including Directors of Social Services, Welsh Local Government Association ("WLGA"), Social Care Wales ("SCW") and the Care Inspectorate Wales ("CIW"). The group also included members that provided significant input from co-dependent areas such as housing, British Red Cross, Wales Council for Voluntary Action ("WCVA"), Care Forum Wales, and Community Health Council ("CHC"). The group was actively used as a networking platform to seek views, test ideas and cascade of information between the sector and the Welsh Government. During the first six months of the pandemic, these meetings were held approximately once per week. The group provided advice, guidance and leadership for all care settings in Wales and focused not only on short term immediate issues/actions in relation to the pandemic but also began to consider medium to long-term considerations (for example winter preparedness, consideration of future Covid-19 waves and efforts to return to a business as usual or covid stable position). The group focused upon registered care homes for adults and children; domiciliary care; supported living; learning disability 'shared lives' arrangements; personal assistants; and unpaid carers.

Workforce Deployment and Well-being

182. Co-chairs of this group were Helen Arthur, Interim Director, Workforce and Organisational Development and Julie Rogers, Deputy Chief Executive/Director of Workforce & Organisational Development, HEIW. This group focused on workforce modelling and wellbeing and also supported the Primary and Community Care Cell in relation to out of hours services. The subgroup's primary focus was to share national information with all key stakeholders; clarify and set out key planning and response structures; gather intelligence about workforce issues and examine and develop responses; identify appropriate contingency measures going forward; and advise on strategic operational response requirements.

Digital Services

183. Co-chairs of this group were Ifan Evans, Director, Technology, Digital and Transformation and Helen Thomas, Interim Chief Executive Officer, NHS Wales Informatics Service. This group fed into a number of the other sub-groups and shared knowledge and information of digital solutions to support what was a very different way of working and delivering services to the people of Wales. The pandemic brought into sharp focus the need to rapidly accelerate a number of digital programmes which had been scoped as part of the vision set out in A Healthier Wales, and the need for system-wide actions to take place in days and weeks that normally would have taken months or even years.

Health Countermeasures

184. This group was chaired by David Goulding, Health Emergency Planning Adviser, and provided a link into the UK Countermeasures Network. The core members from Public Health Wales, NHS Wales Shared Services Partnership ("NWSSP"), the Social Services Integration Directorate and the Health Emergency Planning Unit ("HEPU"). Finance Delivery Unit's staff were added to the Group, along with military liaison at the end of March 2020. The UK Countermeasures Network took forward procurements of supplies and worked on a four-nation basis to maintain essential supplies to the NHS and social care. The subgroup's focus was to access essential supplies and prioritise their deployment; ensure timely mechanisms were in place to deploy stock; monitor and respond to potential supply issues; manage the deployment of pandemic stock

(and other stock, as appropriate); and work with the other UK countries and supplies network.

Essential Services (also referred to as Non-Covid-19 Services)

185. This group was co-chaired by Janet Davies, Deputy Director, Cwm Taf Morgannwg University Health Board Intervention Team and Mark Dickinson, Director, Clinical Networks, NHS Wales Health Collaborative. The sub-group provided central leadership and oversight in relation to the maintenance and recovery planning for essential NHS Wales services not specified in the Covid-19 response. The aim of the group was to work within the World Health Organisation's operational guidance for maintaining essential health services during an outbreak to oversee and to ensure the identification and delivery of essential services to minimise avoidable mortality and significant morbidity from health conditions other than Covid-19. The group considered not only the identification of 'essential services' but also the advice around the delivery of services throughout the phases of the pandemic. The Group had strong links to the Primary and Community Care and Acute Secondary Care Cells which were primarily focused on the direct response to the pandemic.

186. I will detail the work of some of these sub-groups throughout this statement.

187. A Health and Social Services Group Planning and Response Cell was also established consisting of a smaller group providing direct resource to support and help coordinate the Group. The Cell pulled in resources from across the Health and Social Services Group as well as from the NHS Delivery Unit and WHSSC. This support also included a team of Senior Military Planners who were embedded into the Planning & Response Cell. Military Liaison Officers were also deployed to each of the seven local health boards, as well as WAST and Velindre NHS Trust. This team provided ongoing support, co-ordination and integration of the health and social services response and co-ordinated their work with the wider remit of the Welsh Government's Emergency Co-ordination Centre. This Cell included David Goulding, the Welsh Government's Health Emergency Planning Adviser and built on the previous experience and relationship with NHS contingency leads and the strong emergency planning network in Wales.

188. In April 2020 a PPE Supplies Cell was added to the Health and Social Services Group Covid-19 Structure. This was headed up by Alan Brace, Director of Finance, and was directly accountable to me and to Welsh Ministers and had close links with NWSSP who provided PPE stock reports. This Cell was separate but provided regular updates (usually via weekly SitReps), to the Covid-19 Planning and Response Group.

189. As part of the Health and Social Services Group Covid-19 structure another group was formed consisting of Frank Atherton, CMO(W); Jean White, the Chief Nursing Officer for Wales; Albert Heaney, the Director of Social Services; and Samia Edmonds, Chair of the Covid-19 Planning and Response Group; all of whom reported to myself as Director General of the Health and Social Services Group. In terms of structure, this sat between the Minister for Health and Social Services and the Covid-19 Planning and Response Group, but more than anything it was a regular meeting at which myself and others responsible for key areas in the Health and Social Services Group could share information. These meetings covered general updates and sharing of information from the various sub-groups, meetings and interactions we were all engaged in during this period to ensure a co-ordinated Health and Social Services Group approach could be taken and that there was a shared level of understanding. Samia Edmonds, in her internal planning role, reported to me directly in my role of Chief Executive of NHS Wales and worked closely with Frank Atherton and Albert Heaney, noting their particular system responsibilities and Frank's specific role in oversight Covid-19 as Chief Medical Officer and in his advisory role to Cabinet.

190. The membership of NHS organisations within the Covid-19 Planning and Response Group and the deliberate choice to identify co-chairs of subgroups from the NHS, meant we enabled and welcomed views from the health care system routinely and at key moments, to ensure that the direction of travel was supported by the NHS and stakeholders. The NHS views were fed into the Covid-19 Planning and Response group via its members and by the co-chairs and members of the subgroups. It was important to ensure that the NHS voice was available in this way and not just through my NHS Wales leadership role but always in line with the tone of the system. This approach underpinned the reciprocal working used throughout the pandemic response, taking full advantage of the line management of the NHS and available expertise.

191. Part of the information shared as part of the Covid-19 Planning and Response structure was information gathered via local arrangements within health boards from those working on the frontline relating to problems encountered, solutions to problems, or other innovation in order to improve the response to the pandemic. Individual NHS bodies may be able to provide further information on the mechanisms used locally for gathering this information. Information and feedback from the frontline workers would be fed up into the Welsh Government's Health and Social Services Group and shared between NHS bodies via a number of routes including, the regular NHS Executive meetings between myself (and later Judith Paget); the Chief Medical Officers regular meetings with the NHS Medical Directors; the Chief Nursing Officers regular meetings with the NHS Nursing Directors. The information that would be brough to the attention of the Health and Social Services Group and myself as Chief Executive NHS Wales would typically be anecdotal information about what was happening on the frontline of healthcare services, how hard staff were working and the emotional impact of what they were dealing with, I often tried to capture the mood of staff and reflect on their experience in my press conferences and communications with the public or health care system. Particularly in March and April at the Chief Executive calls my NHS Chief Executives reflected on the workforce concerns about getting the virus and the impact of staff absences. This workforce perspective was important during discussions about healthcare testing and PPE supplies as well as understanding whether the guidance issued (particularly on isolation requirements) was clear and supported workers in decision making adequately. Other examples of the type of information regarding the frontline workers which were brought to my attention included concerns from ethnic minority groups voiced through Professor Keshav Singhal, Consultant Orthopaedic surgeon at the Princess of Wales hospital in Bridgend who was also the Chair of the Covid-19 Risk Assessment group. Engagement with the British Medical Association ("BMA") as well as unions and professional bodies such as the Royal College of Nursing ("RCN") was also an important route to receiving the views and perspectives of the healthcare workforce.

192. Additionally, the Welsh Government also received frontline views via the Welsh Partnership Forum for the NHS in Wales which is a tripartite group, sponsored by the Welsh Government consisting of representatives from:

a) the recognised healthcare trade unions and professional organisations for NHS Wales;

b) representatives of senior management for NHS Wales; and

c) representatives from the Welsh Government.

193. This representation was reflected in the leadership of the Welsh Partnership Forum, and meetings were co-chaired by me, in my capacity as NHS Wales Chief Executive, a Union-nominated chair and an NHS chief executive. The main purpose of the Welsh Partnership Forum is the development, support and delivery of workforce policies on a national, regional and local level. The Welsh Partnership Forum also provides strategic leadership on partnership working between employers and employee representatives across NHS Wales.

194. The routine agenda fell away, somewhat, due to the need to pivot our focus to pandemic preparation response, but the forum acted as an important mechanism for communicating directly with frontline healthcare workers and their representatives, and for sharing developments and actions, and responding to areas of concern. The Forum provided an important opportunity to discuss workforce issues such as personal protective equipment availability and use, and vaccination and testing policies for the NHS workforce. While individual NHS organisations has their own structures in place for partnership working and collective bargaining at a local level, this forum was important for engaging with and hearing directly from the NHS workforce at a national level.

195. As I have mentioned previously, I spoke regularly with trade union colleagues throughout the pandemic, and I would also speak to trade union leaders and representatives in advance of significant decisions or actions being taken, in accordance with the Welsh Government's partnership approach to engaging with staff and their representatives.

196. This meant that leads were invited to come to participate alongside me to reflect on areas such as PPE availability and guidance, vaccination and testing. Individual NHS organisations had their own communication and structures with unions but this was an effective forum for common sharing and feedback.

197. In terms of monitoring the efficiency of communication within the healthcare system during the relevant period there was no particular mechanism or process in place within the Welsh Government or the Health and Social Services Group for doing so but as noted above there were a number of routes which the Welsh Government facilitated to enable discussion between NHS bodies.

Funding of the NHS in Wales during the pandemic period

198. The Health and Social Services Group's powers or responsibilities in relation to operational decision-making within the NHS in Wales during the relevant period did not change. As outlined earlier in this statement, the Welsh Ministers are responsible under the 2006 Act for the promotion and provision of a comprehensive health service in Wales in accordance with the 2006 Act. The Welsh Ministers have chosen to discharge that statutory duty by establishing local health boards and making each responsible for healthcare functions in relation to their area. Operational decision making is the responsibility of NHS bodies in Wales however the Welsh Ministers (served by the Welsh Government Department of Health and Social Services) have the power to issue directions to the local health boards and set the strategic national direction of the NHS in Wales and retain certain monitoring and intervention functions as well as responsibility for funding the NHS in Wales.

199. The funding of and accounting processes in place for the NHS in Wales is described above. As set out above, the funding of the NHS in Wales was linked closely to the planning of services on a three-year basis linked to Integrated Medium Term Plans ("IMTPs") submitted by organisations for approval by the Health and Social Services Group and the Minister for Health and Social Services. NHS bodies are directed to prepare IMTPs which, once approved from the basis for the strategic direction of the body for the next three years which is monitored based on the financial spend and whether the objectives set out in the IMPT have been achieved. This is monitored by the Health and Social Services Group and reported to the Minister for Health and Social Services.

200. During the pandemic period, the usual planning process of 3-year IMTPs was not realistic given the need for the NHS in Wales to respond quickly to what seemed like a constantly evolving picture. To ensure the planning principles and mechanisms for

oversight were not lost, the Welsh Government initially asked health boards for weekly plans in the early phase of the pandemic. Once the position started to stabilise this changed to quarterly operational planning cycles were introduced in May 2020 to provide assurance across the system.

201. Operational Planning Frameworks were issued for each quarter to set out the requirements for NHS Wales. These Frameworks were issued as directions to NHS bodies (using the powers in the 2006 Act) and took into account the modelling and RWCS coming from the Technical Advisory Cell and Technical Advisory Group to enable NHS Wales to plan in the short term with a particular focus on NHS capacity. The quarterly plans were aligned with the ministerial priorities as set out in 'Leading Wales out the Coronavirus pandemic: a framework for recovery' as exhibited in **AGM3WGO01/44 - INQ000349353** which required the following 'harms' to be considered when making decisions:

a) direct harm to individuals from SARS-CoV2 infection and complications including for those who develop severe disease and in some cases sadly die as a result;

b) indirect harm caused to individuals if services including the NHS became overwhelmed due to any sudden large spike in demand from patients with Covid-19 on hospitals, critical care facilities and other key services;

c) harms from non-Covid-19 illness, for example if individuals do not seek medical attention for their illness early and their condition worsens, or more broadly from the necessary changes in NHS service delivery made during the pandemic in Wales to pause non-essential activity;

d) socioeconomic and other societal harms such as the economic impact on certain socioeconomic groups of not being able to work, impacts on businesses of being closed or facing falling customer demand, psychological harms to the public of social distancing and many others; and

e) (The fifth harm added by the Technical Advisory Group in July 2021, as outlined in the paper exhibited in **AGM3WGO01/45- INQ000239550**) harms arising from the way Covid-19 has exacerbated existing, or introduced new, inequalities in our society.

202. During the pandemic period the following frameworks were issued to the NHS in Wales based on which each organisation would need to plan the services that would be delivered in their local areas:

    i. NHS Wales Operating Framework - quarter 1, exhibit **AGM3WGO01/46 - INQ000182468** refers;

    ii. NHS Wales Operating Framework - quarter 2, exhibit **AGM3WGO01/47 - INQ000182460** refers;

    iii. NHS Wales Operating Framework – quarter 3 and 4, exhibit **AGM3WGO01/48 - INQ000182474** refers; and

    iv. Welsh Government Winter Protection Plan 2020-21, exhibit **AGM3WGO01/49 - INQ000300011** refers.

203. In December 2020 the Planning Framework 2021-22 was issued requiring organisations to develop an annual plan for 2021-22. The 2021-22 Framework built on the quarterly frameworks issued in 2020-21 and drew on the priorities set out in the Welsh Government's Winter Protection Plan. The IMTP Planning framework (as detailed above in paragraphs 73 to 75) was brought back for the 2022-2025 period and the statutory process recommenced.

204. In terms funding for the NHS during the pandemic period the Welsh Ministers remained responsible for the funding of the NHS in Wales. The Welsh Ministers have powers in the NHS (Wales) Act 2006 which enable additional funding to be provided to NHS bodies if necessary.[53]

205. Local health boards and special health authorities draw down cash on a monthly basis to support their overall allocation. This is a well-established and long running arrangement. Welsh Government officials in Finance, in the Health and Social Services Group, worked closely with colleagues in Finance teams in NHS Wales to ensure that cash flows for additional Covid-19 support were made in a timely manner, whilst adhering to the appropriate governance requirements. Welsh NHS trusts draw

[53] Section 2 and section 174 of the NHS (Wales) Act 2006

down funding from Welsh Government via an invoicing arrangement. Welsh Government officials in Finance, in the Health and Social Services Group, worked closely with colleagues in Finance teams in Welsh NHS trusts to ensure invoices were paid in a timely manner and funding was in place to react quickly where needed.

206. To reflect, the dramatic effect on how organisations would be expected to operate in this unprecedented environment of the impending pandemic, guidance was issued to NHS Wales bodies on 30 March 2020 which offered the following principles to be applied in decision-making:

a) Due consideration is given to regularity in relying on legal powers, propriety and meeting the standards of 'Managing Welsh Public Money', and value for money supported by an assessment of the realistic options available to you at the time.
b) Decisions taken must be rational and justifiable with due consideration of all options and risk. If approval is required then it should be sought and justification for decisions should be recorded, if not at the time, then subsequently.
c) Individuals and organisations should ensure that decision-making conduct is in line with Nolan Principles, with integrity at the heart of decisions and with no conflict of interest affecting or appearing to affect decisions.
d) During emergencies, organisations inevitably are more vulnerable to the risk of fraud. Therefore, a continued focus on good governance and potential fraud is essential.
e) If any organisation has any concerns in any aspects of their decision-making process and revised governance arrangements, in addition to seeking advice of Welsh Government officials, they should ensure the continual involvement of Audit Wales in their activities to refocus decision-making processes.

207. Given the immediate challenges presented by the Covid-19 pandemic, it was recognised that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis. In keeping with the principles and spirit of guidance, the routine financial arrangements were adapted to a supportive and balanced focus in ensuring core minimum requirements were in place to support all organisations at this challenging time. In this environment, financial guidance advocated the need to ensure that:

a) There were clear and pragmatic financial arrangements in place which minimised any disruption to the system.

b) Business continuity arrangements are effective.

c) Frameworks to support effective decision-making are clear.

d) Core financial assumptions and positions are clear and monitored, but with a light touch approach whilst maintaining sufficient clarity on minimum key measures.

208. Local health boards produced local Covid-19 action plans covering a range of measures. More specific proposals for national response measures were also received.

209. Monitoring of Covid-19 expenditure was subject to the same arrangements as other 'core' NHS expenditure under the well-established process of Monthly Monitoring Returns (MMRs). Every NHS organisation in Wales was expected to incorporate reporting information on Covid-19 spend into their regular financial monitoring returns each month and where allocations were not going to be fully spent, these were returned or approved for re-allocation to a different Covid-19 pressure area.

210. Organisations were instructed to maintain a distinction between reporting on their core NHS funding and the additional sums they were receiving to respond to the Covid-19 pandemic.

211. Welsh Government officials in policy departments and finance in the Health and Social Services Group worked closely with colleagues in NHS Wales to understand the emerging demands that Covid-19 pandemic was presenting. Additional support and scrutiny were provided by colleagues in the NHS Finance Delivery Unit.

212. Enhanced processes were also instigated with a regular meeting of Directors of Finance meeting every Wednesday, where any emerging issues could be discussed. This was complimented by the regular 'Finance Cell' meetings between the Director of Finance and Deputy Director of Finance within the Health and Social Services Group and the Director of Finance for the NHS Finance Delivery Unit.

213. Where proposals and requests for funding were being received, these were considered at a Welsh Government official level initially, with the appropriate level of scrutiny and challenge and then decisions to approve additional Covid-19 funding support were taken by Ministers through the Ministerial Advice route. This is a well-established process that requires formal advice and decisions to be recorded on the Ministerial Advice template (MA). Where required, these MAs were also considered by the 'Star Chamber' set up by the First Minister, described below.

214. In the early part of the pandemic the Health and Social Services Group was able to re-prioritise funds internally and reallocate funds quickly to pressured areas. To maximise the impact of available resources, a Covid-19 reserve was created from reallocation of Welsh Government Budgets, transfers from reserves and UK government consequential funding. It was recognised that the response to the pandemic would place unprecedented pressure on the Welsh Government budget for 2020-21 due to the sheer volume of significant finance related decisions that would need to be taken by Ministers, and the challenge of assessing and prioritising these to maximise the impact of available resources. Strategic oversight of all major funding decisions was therefore required. Accordingly, a group named "The Star Chamber" was established by the First Minister in March 2020 to oversee and co-ordinate the Welsh Government's overall fiscal response to the pandemic. The group supported the Minister for Finance in relation to the deployment of available resources held centrally to meet the challenges of Covid-19 as well as supporting the re-prioritisation and re-purposing of funds.

215. The Welsh Government does not hold a full log of requests from health boards and Trusts that would show proposals agreed, agreed in part or that were not agreed. Very few, if any, proposals from health boards and Trusts were not carefully considered and then subsequently granted some level of funding. From our financial records and accounts, funding was agreed to support key areas including:

    a) Increased staffing levels
    b) Critical care capacity and field hospitals
    c) The use of private hospitals
    d) Primary care including GP surgeries e.g. video and online consultations.

e) Provision of healthcare and treatments for patients with Covid-19
f) Research & development during the pandemic.
g) Convalescent plasma therapy
h) Support for Hospices and palliative care.
i) Discharge of patients from hospital and support in social care
j) Support for doctors, nurses and other healthcare staff for helping to deal with the impact of the pandemic.
k) Infection control and preventing the spread of Covid-19 within health and care settings.
l) Support and communication on shielding and the impact on the clinically vulnerable. Diagnosis and treatment of post-Covid-19 conditions including Long Covid.
m) Bereavement support.
n) Capital investment in equipment and premises that supported the delivery of the measures above.
o) Extension of the existing Influenza vaccination programme (for greater coverage)
p) Introduction of the Covid-19 vaccination programme.

216. Despite the challenges posed by the pandemic, nine of the 11 NHS organisations operated within their budgets in 2020- 2021 and 2021-22. In 2020-21 Hywel Dda University Health Board and Swansea Bay University Health Board were unable to balance their books in-year, reporting deficits in line with their initial plans developed prior to the pandemic. The overall outturn for NHS Wales was a deficit of £48m, an improvement from £89m in 2019-20 despite the circumstances of the pandemic. The summarised accounts for NHS Wales were laid before the Senedd in August 2021 and are exhibited to the statement, reference **AGM3WGO01/50 - INQ000182567**. Hywel Dda and Swansea Bay University local health boards continued to report deficits in line with their initial plans developed prior to the pandemic in 2020. The summarised accounts for NHS Wales were laid before the Senedd in August 2022 and are exhibited to the statement, reference **AGM3WGO01/51 - INQ000182566.** As I outlined earlier in this statement the NHS Wales is funded by the Welsh Government and the HSS MEG includes funding for NHS Wales. It is important to note that while NHS Wales was in deficit the overall HSS MEG was able to offset the deficit as a result of considered

funding decisions throughout the pandemic period which enabled the HSS MEG to be balanced.

217. I have been asked to describe the additional funding was made available to the NHS. In the financial year 2020-21, Welsh Government issued additional Covid-19 funding allocations to the NHS in Wales, from budgets within the Health and Social Services Group. These totaled £1.170 billion for revenue expenditure and £133 million for capital purposes. This funding went to local health boards, trusts and special health authorities in Wales. The table below, reproduced from the NHS Wales accounts, exhibited above in AGM3WGO01/50 - INQ000182567, provides a breakdown of the additional funding provided to NHS organisations under different headings and areas of response.

Table 1 – NHS Wales Summarised Accounts

32. Other (continued)
32.3 Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to NHS Wales bodies:

	2020-21 £000
Capital	
Capital Funding Field Hospitals	50,022
Capital Funding Equipment & Works	77,013
Capital Funding other	6,077
Welsh Government Covid 19 Capital Funding	**133,112**
Revenue	
Sustainability Funding	331,181
C-19 Pay Costs Q1 (Future Quarters covered by SF)	53,846
Field Hospital (Set Up Costs, Decommissioning & Consequential losses)	136,080
PPE (including All Wales Equipment via NWSSP)	194,262
TTP- Testing & Sampling - Pay & Non Pay	55,232
TTP - NHS & LA Tracing - Pay & Non Pay	37,839
Vaccination - Extended Flu Programme	4,592
Vaccination - COVID-19	27,728
Bonus Payment	104,939
Annual Leave Accrual - Increase due to Covid	92,075
Urgent & Emergency Care	25,578
Support for Adult Social Care Providers	27,201
Hospices	9,300
Independent Health Sector	27,677
Mental Health	10,203
Other Primary Care	10,776
Other	21,975
Welsh Government Covid 19 Revenue Funding	**1,170,484**

The Covid 19 Other Capital Funding relates to Cwm Taf Morgannwg ULHB and Velindre University NHS Trust. Further details may be found in the statutory accounts of these bodies.

218. There were allocations made on a national basis for Covid-19 pressures affecting all organisations as well as some very specific allocations which were only needed by one or more organisations.

219. Local health boards and trusts have responsibility to deliver plans and services to meet the needs of the populations they serve, including Covid-19 response measures.

Therefore, funding allocations were made at an organisational level in support of local services as part of local plans that were developed by local health boards. In addition, national services were provided by, for example, Public Health Wales and NHS Wales Shared Services Partnership (NWSSP), and funding was allocated on an organisational basis to support all Wales activity and services. Examples of this included Public Health Wales leading on testing and NWSSP leading on PPE procurement.

220. In terms of the processes in place by which requests for additional funding for the healthcare system during the pandemic were considered, we worked in a very collaborative way from early on with the NHS in Wales. The Welsh Government does not hold a full log of requests received from local health boards and Trusts. There was regular dialogue and engagement with every local health board and trust. We proactively reprioritised funding within the Health and Social Services Group very early on, with the intention of re-directing it to support the front-line response. The existing structure and nature of the relationship between the Welsh Government and the NHS in Wales meant that we were able to be both proactive in offering support and reactive to any information that was coming in from the NHS. We worked diligently, and flexibly, throughout the year to ensure local health boards had enough funding cover, and timely cash flows, to deal with the challenges they were facing locally. We did receive some specific funding requests, as stated, but we generally worked towards recognising the pressures across the system nationally and those then fed into the local health board plans to respond in their localities.

Impact of Covid-19 on users of the healthcare system

221. Prior to and during the pandemic period we were conscious of the significant impact the health care system could have upon groups such as the disabled, clinically vulnerable, ethnic minorities and those with poor socio-economic backgrounds or with existing health inequalities.

222. A key principle adopted by the Welsh Government during the pandemic centred on whether the measure being introduced or removed would have a '*high positive equality impact*'. In addition, the Welsh Government was mindful of the need to mitigate against

the four harms (later expanded to include a fifth harm) arising from the pandemic as outlined above in paragraph 201.

223. Throughout this period decision making by NHS Wales and Welsh Ministers continued to be assessed against their statutory duties. The Welsh Ministers and NHS Wales were required to undertake equality impact assessment as part of their duties under the Equality Act 2010.

224. Impact Assessments are an important part of policy making, and the Welsh Government has statutory obligations or has made commitments for the consideration of a number of areas of impact when developing policy. These include equality, the Welsh Language, biodiversity, children's rights, rural-proofing, data protection, justice, health, privacy and a range of environmental impacts. For decisions of a strategic nature there is also a duty to consider their socio-economic impact.

225. Each NHS body would have been undertaking these assessments at a local level in respect of local decisions and hold that information as part of their individual organisation's records.

226. Within the Welsh Government the standard tool used to assess impact is the Integrated Impact Assessment ("IIA") which brings together all impact assessments into one comprehensive document. The document also requires consideration of how the policy proposal fits with the priorities and vision of the programme for government, and how it contributes to the social, cultural, economic and environmental well-being of Wales (aligning with the Well-being of Future Generations (Wales) Act 2015 and the sustainable development principle).

227. Ministers would also be provided with information about the economic and societal implications of the options under consideration. Ministerial advice recommending decisions for the health care system would include impact assessments of the options, including the impacts on particular socio-economic groups and groups with protected characteristics. Summaries of impact assessments were published were possible. The need to make decisions at pace for the protection of public health meant that it was not always possible to undertake full impact assessments in line with best practice for policy decisions of the measures being considered.

228. In respect of decisions taken by the Welsh Government during the pandemic, due to the urgency of the situation and exponential increases in Covid-19 transmission decisions at the start of the Covid-19 pandemic were often made without a formal assessment of the impact on vulnerable people. However, issues of equality and vulnerability were part of the consideration of some of our early actions and part of the balancing of Covid-19 related harms as outlined above and set out in 'Leading Wales out of the coronavirus pandemic' (exhibited earlier in AGM3WGO01/44 - INQ000349353).

229. In making decisions the Welsh Government would seek to engage the All-Wales NHS Equality Leadership Group, as well as others where possible to ensure consideration of equality issues as part of the process despite the absence of a formal Equality Impact Assessment ("EIA"). Early in the pandemic the Equality Leadership Group considered the disproportionate effect that Covid-19 infections were having on health and care professionals from Black, Asian and Ethnic Minority backgrounds. Recommendations from this Group were fed into the wider First Minister's Black, Asian and Minority Ethnic Advisory Group which I have detailed further below.

230. The work of this Group was fed into the Race Equality Action Plan for Wales.

231. Additionally, particularly in respect of the Covid-19 Restrictions in Wales, Public Health Wales provided a wealth of data via their Public Engagement Survey which they started conducting around April 2020. Each week, Public Health Wales would conduct interviews with people across Wales, to understand how Covid-19 and the measures being used to prevent its spread were affecting the physical, mental and social wellbeing of people in Wales. The outcome of this survey would be provided to the Welsh Government's Knowledge and Analytical Services team and provided an important insight into the impact of the Welsh Government's response to Covid-19.

232. The statutory duty to assess impacts applies to proposed policies and practices, the review of any policy or practice and any proposed revision of a policy or practice[54]. Therefore, usually the impact assessment would be undertaken prior to any major policy decision. However, there were decisions made to respond to the public health

[54] As set out in the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011

emergency, where it was not possible to produce and publish an Equality Impact Assessment alongside them. In August 2020, the Senedd's Equality, Local Government and Communities Committee recommended that the Welsh Government should ensure that each major policy or legislative decision during the pandemic should be accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since that time published dozens of impact assessments related to the Covid-19 pandemic on its website. These EIA's include the findings from Public Health Wales 's Public Engagement Survey.

233. A list of all published EIAs related to Covid-19 is provided in exhibit **AGM3WGO01/52 - INQ000227405**. The following equality impact assessments relate to the scope of Module 3 and have been summarised below:

a) Impact of shielding on vulnerable individuals: integrated impact assessment **(AGM3WGO01/53 - INQ000066205)** noted the most significant impact 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. It noted the real risk to the health and well-being of isolated shielding individuals without this programme, as not providing priority access to food, medicines, social and other services could have led to people risking their health to leave their homes and shop and/or going without food, medicines and essentials. There was a significant impact in terms of financial cost but this was fully taken into account and was considered proportionate as part of an emergency response to the pandemic. Neither this assessment nor any other conducted by the Welsh Government considered if the shielding policy reduced the incidence of infection in the Clinically Extremely Vulnerable. Work was however undertaken by researchers at Swansea University.

b) Food boxes for shielded people: integrated impact assessment (**AGM3WGO01/54 - INQ000087136)**. This was issued at the same time as the above assessment and should be read together. This assessment noted the most significant impact was positive, with the creation of an infrastructure and methodology for ensuring that access to food can be provided to members of society that the Chief Medical

Officer had asked to shield for the duration of the pandemic. There was a real risk of the loss of life to shielding individuals if they were unable to procure food supplies and needed to leave their homes. The food box delivery scheme enabled shielding people to remain safe. The other significant impact was cost. This was an unexpected spend on a scheme with a short life. The processes developed and other learning points from supplier managements and contract negotiations may form the basis for a contingency and response plan for us in any future crisis situations.

c) All Wales Covid-19 Workforce Risk Assessment Tool: integrated impact assessment (**AGM3WGO01/55- INQ000023242**). The most significant impact of the All Wales Covid-19 Workforce Risk Assessment Tool was that it identified health and social care workers who are at greater risk of severe Covid-19 infection or death to protect them from avoidable harm and save lives. Following completion of the self-assessment part of the risk assessment tool the individual should discuss the risks with their line manager to mitigate, manage and minimise these and promote worker safety and wellbeing. The All Wales Covid-19 Workforce Risk Assessment Tool may identify further vulnerable and at-risk staff who need to be redeployed from front line patient facing roles. Therefore, this will need to be accounted for in local health boards' planning to ensure our health and social care system is as prepared, equipped and resilient as it can be for the weeks and months ahead.

234. In addition to Equality Impact Assessments and there were several expert advisory groups established to support ministerial decisions on the impacts of Covid-19 on those with protected characteristics. The key expert advisory groups are set out below.

Advisory groups

235. The Welsh Government had an established practice of working with advisory groups to consider the impact of disadvantaged groups and those with protected characteristics under the Equality Act 2010. Prior to the Covid-19 pandemic the following groups existed:

a) Race Equality Forum,

b) Disability Equality Forum,
c) Faith Communities Forum,
d) Third Sector Partnership Council,
e) Strengthening and Advancing Equality and Human Rights in Wales Steering Group
f) Refugee and Asylum Seeker Taskforce, and
g) Policing Partnership Board.

236. These forums and advisory groups met with greater frequency from April 2020 onwards. These were important meetings and were chaired by Jane Hutt, who during this period held the roles of Deputy Minister and Chief Whip covering the equalities, Violence Against Women, Domestic Abuse and Sexual Violence, third sector and the crime and justice portfolio between January 2020 and May 2021 and then Minister for Social Justice from May 2021. The input from these forums and groups were particularly significant in assessing the broad impacts of Covid-19, but were not specific to the healthcare system, issues linked to the healthcare system would however be considered.

237. For example, the Disability Equality Forum engaged with Welsh Government officials and inputted or made representations on a broad range of concerns as to the impact of Covid-19 on disabled people in Wales. With specific reference to matters within the scope of Module 3 these concerns included, for example:

a) The need for all public communications regarding the pandemic to be available in accessible formats;
b) The provision of PPE for unpaid carers of people shielding;
c) The need for shielding groups to be represented as part of the 21-day review process, to ensure that the impact on those groups of the easing of restrictions was taken into account;
d) The need for clear face masks to assist those who rely on lip reading to communicate.
e) The easing of shielding restrictions, including the removal of the passport system which resulted in the forced isolation for people who have a suppressed immune system.

238. All such concerns were fed back to the Minister for Health and Social Services by Welsh Government officials. This input was taken into consideration when making key decisions. For example, on the 31 July 2020 Shielding was paused in the other nations but in Wales it continued until the 16 August 2020. This decision to continue Shielding in Wales was made by the Minister for Health and Social Services following advice provided on the 2 July 2020 by the Chief Medical Officer for Wales. A copy of this advice is exhibited in **AGM3WGO01/56 - INQ000136796.** The Chief Medical Officer for Wales advice at the time was to align with the other nations. The Minister for Health and Social Services, having considered input from the Disability Equality Forum provided by the Deputy Minister and Chief Whip about the need for adequate warning of changes, decided to continue with the plan for shielding advice to continue until the 16 August 2020. A copy of the Deputy Ministers email is exhibited in **AGM3WGO01/57 - INQ000252522** and the decision by the Minister for Health and Social Services is confirmed in exhibit **AGM3WGO01/58 - INQ000252524** in which the Minister for Health and Social Services reflects on moving people to an earlier date being fraught with difficulty and the concern that people felt abandoned rather than liberated by being taken out of shielding. Ultimately the advice on shielding was of course just that, advice and not a requirement, so on this basis the Minister decided to keep the advice in place.

239. The following advisory groups were also established during the pandemic to provide information in order to inform impact assessments and which had a specific role in helping to shape the response of the healthcare systems to the Covid-19 pandemic throughout the pandemic period.

Technical Advisory Group

240. The Technical Advisory Group (or 'TAG' as it was commonly referred to) and its subgroups was the main source of expert advice during the pandemic period in Wales. TAG comprised of internal (civil servants) and external scientific and technical experts (non-civil servants) who provided independent science advice and guidance to the Welsh Government in response to Covid-19. The TAG terms of reference are provided in exhibit **AGM3WGO01/59 - INQ000177396.**

241. Attached to TAG was the Technical Advisory Cell (referred to as "TAC") which distilled the information and discussion from the TAG and provided updates to myself as well as the Chief Medical Officer for Wales, Minister for Health and Social Services, senior civil servants and special advisers (e.g. Clare Jenkins). The organisation and relationships within the scientific structure changed over time and by the end of March 2020 the concept of 'TAC' as holding the internal Welsh Government civil service coordination function and 'TAG' as the multi-professional expert advisory group had been formed.

Technical Advisory Group - Subgroup Socio-economic Harms

242. The Socio-economic Harms subgroup of TAG oversaw projects that aimed to better understand the impact of Covid-19 on already disadvantaged sectors and groups in Wales. The subgroup used evidence synthesis to identify potential policy options that may mitigate these social, economic and equity harms from Covid-19. The subgroup also oversaw the evaluation of emerging national and international research and evidence on Covid-19 in the context of the economy and the potential harm that may be caused to specific sectors and groups in Wales.

The Black, Asian, Minority Ethnic Covid-19 Advisory group

243. The First Minister's Black, Asian, Minority Ethnic Covid-19 Advisory group was convened on 29 April 2020 and met until 20 April 2021. The group was established in response to the concerns that some ethnic groups were disproportionately impacted by Covid-19 with consequent adverse health outcomes.

244. The group was chaired by District Judge Ray Singh, CBE who was the Chair of the Race Council Cymru.

245. The terms of reference of the First Minister's Black, Asian, Minority Ethnic Covid-19 Advisory group were agreed on 6 May 2020. Exhibit **AGM3WGO01/60 - INQ000066077** refers.

246. The group included representation from Welsh Government officials; NHS and care workers from ethnic minority communities; Public Health Wales; and local health boards and trusts; and drew in expertise from those involved with data collection and

analysis, workforce management, occupational health, quality and safety, academic, and any other additional expertise as required. The work of the Advisory Group informed and helped protect the health and wellbeing of our communities, and provide more tailored advice for health, social care and other workers.

247. Two subgroups were established as part of the advisory group, the Socio-economic subgroup chaired by Professor Emmanuel Ogbonna and the Risk Assessment subgroup chaired by Professor Keshav Singhal.

248. The report of the Socio-economic Subgroup, published on 25 June 2020 and exhibited in **AGM3WGO01/61 - INQ000227599** emphasised the need to ensure sufficient PPE was available both now and for the future highlighting that effective supplies of suitable quantities of PPE are essential to protect the workforce in conditions where the risk of Covid-19 infection cannot be mitigated in other ways.

249. The remit of the Risk Assessment Subgroup was primarily to consider the evolving evidence, in order to make recommendations to the First Minister's Advisory Group on a workplace risk assessment for frontline health and social care workers in Wales. The Risk Assessment Subgroup considered a range of approaches to risk assessment drawing on existing tools in use elsewhere as well as a wide range of evidence and numerous reviews. The group concluded that it was a combination of various factors which contributed to the severity of infection including age and ethnicity. This led to the production and refinement of the All Wales Covid-19 Workforce Risk Assessment Tool, a simple, easy to use, self-assessment tool designed to be suitable for use for all health and social care staff, regardless of ethnicity. A copy of the tool is exhibited above in AGM3WGO01/55- INQ000023242. The Tool includes signposts to health and wellbeing resources as well as the existing and continuing behaviours to avoid Covid-19 infection. The Tool was further amended to suit the context of different workplaces, with a sector specific version available for the education sector as well as a more generic version for 'other sectors.'

250. The terms of reference for the Risk Assessment subgroup also included consideration of the approaches in other UK countries and recommend any interventions to protect against Covid-19, including implications for workforce and safe, effective PPE usage. In the report of the subgroup published October 2021 and exhibited in

AGM3WGO01/62- INQ000282020 the risk assessment subgroup observed that those from minority ethnic communities may have been facing bullying and microaggressions regarding PPE availability and as a result maybe be more reluctant to speak out regarding PPE availability.

251. The Advisory Group and its subgroups worked with stakeholders from ethnic minority communities and expert advisers within Wales and across the UK, to work at pace, to share information and consider options to redress the impact of the pandemic on the vulnerable populations. The Advisory Group were tasked with advising the First Minister and Cabinet.

252. On 22 June 2020, the Socioeconomic subgroup produced a report highlighting the disproportionate impact of the pandemic on minority ethnic communities, a copy of which is exhibited above in AGM3WGO01/61–INQ000227599. The report made 37 recommendations, of which the following related to the healthcare sector:

    a) Take immediate action to improve the quality of recording of ethnicity data in the NHS and across health and social care services to ensure parity of data collection, monitoring and reporting from minority ethnic communities. It was recommended that this was supported by qualitative research into the best methods for this, including lobbying to include ethnicity on death certification and birth certificates.

    b) Address any unfair or illegal discrimination at work in, or by users of, NHS Wales, through renewed attention to anti-oppressive practices, equality and diversity competences, documenting lived experiences of workers from minority ethnic communities, and systematic Equality Impact Assessments specific to ethnicity.

    c) The implementation of Black, Asian and Minority Ethnic Staff Networks/Groups supported by Trade Unions in local health boards should be set up to allow a safe space for staff members from minority ethnic communities to express concerns without the threat of unfair action from line managers and above.

    d) Develop a clear multi-channel communications strategy for health and social care in partnership with Public Health Wales, Welsh NHS Confederation and ADSS or SCW for social care and minority ethnic communities, which identifies effective channels to disseminate information and includes funding for targeted outreach

and consultation activities. This approach may be effective in increasing ethnicity reporting on official forms.

e) Monitor health and social care communication strategies to assess the effectiveness of reducing cultural and language barriers and increasing the uptake of screening and health promotions from ethnic minority communities.

f) Fund a Wales-wide health promotion programme aimed at those from minority ethnic communities similar to the 'Barefoot' Health Workers Project33 which employed health practitioners from African Caribbean, Asian, Arabic, Somali backgrounds to identify health needs in their representative communities, and to develop and deliver culturally appropriate activities to address their needs.

g) Disseminate communication that GPs are still open via phone calls and other means. Longer term, there needs to be easier access to GP's through community day clinics in economically deprived areas.

h) Undertake a review of existing health and social care in partnership with minority ethnic communities, organisations and patients to evaluate appropriateness of service to improve future delivery and reduce health risks for people from minority ethnic communities.

i) Commit to support and fund practical ongoing actions in providing appropriate, equitable, and culturally competent mental health services to individuals from minority ethnic communities to help address the acknowledged inequities that exist in mental health take-up and service provision. To be achieved through utilising the Royal College of Psychiatrists in Wales endorsed Black, Asian and Minority Ethnic Mental Health Cultural Competence Certification Scheme and any other such practical actions.

253. On 24 September 2020, the First Minister gave a detailed response to the report and its recommendations as exhibited in **AGM3WGO01/63 - INQ000300238**, noting that action in relation to many of the recommendations was already underway, had been completed or commitment had been made by the Welsh Government to take further work forward.

254. A summary report on the First Minister's Black, Asian, Minority Ethnic Covid -19 Advisory group was published in September 2021, describing the creation and work of the subgroups as set out above. Exhibit **AGM3WGO01/64 - INQ000066078** refers.

Covid-19 Moral and Ethical Advisory Group Wales

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

256. The terms of reference of CMEAG - Wales were published on 4 May 2020. Exhibit **AGM3WGO01/65 - INQ000066079** refers.

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

258. CMEAG considered a number of issues including priority areas for attention in maintaining essential NHS services. A copy of the *Coronavirus: ethical values and principles for healthcare delivery framework* is exhibited in **AGM3WGO01/66 INQ000081000.** This framework formed the basis of the clinical ethical support for healthcare decision making in Wales. This set out the following core principles:

a) Respect

b) Minimising the overall harm from the pandemic

c) Fairness

d) Working together

e) Reciprocity

f) Keeping things in proportion

g) Flexibility

h) Good decision-making

259. In terms of good decision making and the clinical ethical support for healthcare decision making the framework noted the following considerations:

a) those making decisions about healthcare act with openness and transparency, in line with professional and legal responsibilities, and;

b) consult people as much as possible in the time available and provide adequate time for their decision making (with an advocate if wished), especially around end of life care and do not attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

c) involve people as much as possible in aspects of care planning that affect them, taking into account their individual needs and preferences

d) promote equity by assessing and responding to individual need, avoiding blanket policies based on protected characteristics especially disability or age

e) take into account all relevant views expressed and be open to challenge

f) be clear about what decisions need to be made, and the model of care or analysis being applied

g) be open about what decisions have been made, and why, and who is responsible for making them

h) try to ensure that no person or group is excluded from being involved in decision making that affects them

i) be accountable for the decisions taken or not taken

j) take decisions reasonably, rationally, based on evidence, with a clear, practical process

k) record decisions and actions along with the justification or reasons for them

260. This framework was applied in determining the areas of non-covid healthcare that was identified as priority services as set out in the Maintaining Essential Services during Covid-19 guidance that was issued by the Welsh Government, outlined in detail later in this statement under the section headed maintaining essential services at paragraph 599.

261. I understand that the Inquiry's final modules will specifically investigate impact and inequalities in the context of public services in which the work of some of these advisory groups, particularly the Disability Equality Forum, will be key to understanding the broader impact of decisions on the people of Wales. During the initial stages the focus was on vulnerabilities, particularly clinical vulnerabilities, which reflected our understanding of the immediate impact of the virus as a public health issue. The setting up of this group in May 2020 marked an important shift in our understanding of the broader impacts of the virus.

Working with others

NHS Wales

262. The Health and Social Services Group worked with a number of bodies and committees which were part of the NHS in Wales structure, detailed in paragraphs 96 to 117 of this statement:

1. NHS Wales Shared Services Partnership ("NWSSP")
2. Joint Committee Welsh Health Specialised Services Committee ("WHSSC")
3. Joint Committee Emergency Ambulance Service Committee ("EASC")
4. National Imaging Academy Wales ("NIAW")
5. Welsh Risk Pool Service ("WRPS")
6. NHS Delivery Unit ("NHSDU")
7. NHS Finance Delivery Unit ("FDU")

8. NHS Wales Health Collborative

9. NHS Wales Informatics Service ("NWIS")

10. NHS Wales Improvement Cymru

11. Welsh NHS Confederation

12. Regional Partnership Boards

13. Public Service Boards

14. Emergency Medical Retrieval and Transfer Service Cymru

263. As outlined above, one of the strengths of NHS Wales was its size and close proximity of its organisation to each other and to the structures of Welsh Government. This was also true in the case of other bodies in Wales which enabled NHS Wales access to a range of support and information in planning and responding to the pandemic. I have outlined below some of the larger national bodies which NHS Wales would have worked with but highlight that locally there would have been other important contacts for NHS Wales. NHS Wales would also have worked closely with local authorities, social service directors, third sector organisations, and emergency services in their local areas in addition to working within the Regional Partnership Boards and Public Service Boards outlined in the exhibit referred to above.

Healthcare Inspectorate Wales

264. Healthcare Inspectorate Wales ("HIW") is the independent inspectorate and regulator of healthcare in Wales. Its core role is to inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. It aims to provide an independent view on the quality of care delivered by the NHS and independent healthcare services across Wales.

265. The majority of the powers and functions that HIW exercises are in fact conferred on the Welsh Ministers and exercised by HIW on their behalf. HIW is not a subordinate element of, or integral to, the Welsh Government's Health and Social Services Group,

which is most closely concerned with the services upon which HIW reports and inspects. It is deliberately separated from the Health and Social Services Group and the Minister for Finance and Local Government is responsible for the oversight of audit, inspection and regulation as they relate to public services, including the organisation arrangements for HIW. The Chief Officer of HIW is therefore able to monitor, evaluate, review, assess, and report on the quality and provision of healthcare services, without prejudicial pressure or improper constraint. Exhibit **AGM3WGO01/67- INQ000182578** provides the current Memorandum of Understanding between HIW and the Welsh Ministers.

266. During the pandemic period HIW prepared a number of informal briefings to the Minister for Health and Social Services on the performance of certain aspects of the healthcare system. These are exhibited below:

a) Informal Ministerial Briefing – Healthcare Inspectorate Wales' Response to COVID–19, dated 30 April 2020 (**AGM3WGO01/68 - INQ000182579**): HIW's outward facing inspection was postponed and resources shifted to support the independent sector and enable the provision of safe and effective care during the pandemic. HIW's approach during the pandemic focused on reducing the burden of its work on healthcare setting, whilst still delivering its statutory functions; supporting the NHS, Welsh Government and other organisations in responding to the pandemic; maintaining an oversight of healthcare services; and preparing HIW to enable a swift recovery post pandemic.

b) Informal Ministerial Briefing - Healthcare Inspectorate Wales – Inspection of two field hospital/surge capacity sites in Hywel Dda University Health Board, dated 11 December 2020 (**AGM3WGO01/69 - INQ000182522**). The inspections found that appropriate processes were in place to provide safe and effective care to patients, with a small number of minor issues noted which were already in process of being remedied and which were subsequently confirmed to have been addressed.

c) Informal Ministerial Briefing – Healthcare Inspectorate Wales –Mass Vaccination Centres, dated 10 February 2021 (**AGM3WGO01/70 - INQ000182524**). This set out HIW's plans to inspect Mass Vaccination Centres, with the aim to publish one

report per health board following each inspection, and a summary of all the findings in a new Quarterly Insight Bulletin in April 2021.

d) Informal Ministerial Briefing – Healthcare Inspectorate Wales – Embargoed Report – Field Hospital Report, dated 19 March 2021 (**AGM3WGO01/71 - INQ000182532**). The inspection of a field hospital within Betsi Cadwaladr University Health Board found that while significant effort had one into the planning and mobilisation of the field hospital in order to provide safe and effective care, patients had not consistently received the required standard of care. The report added that the health board was open and engaging in listening to feedback and HIW had since received sufficient assurance that actions had been taken in response to the issues identified.

e) Informal Ministerial Briefing - Healthcare Inspectorate Wales – Mass Vaccination Centres – Letter to local health boards – Immediate Assurance Issues; dated 22 March 2021 (**AGM3WGO01/72 - INQ000182580**). This report noted that while Mass Vaccination Centres were largely operating in a safe and effective way with a highly motivated workforce, HIW had identified, and communicated to health boards, some key issues within some health boards: vaccines being left unsupervised and not checked between preparation and administration; a lack of clinical or environmental audit activity; security, fire regulation compliance and emergency evacuation issues; and a lack of checks of resuscitation equipment.

f) Informal Ministerial Briefing – Healthcare Inspectorate Wales – findings from assurance work on Mass Vaccination Centres dated 21 May 2021 (**AGM3WGO01/73 - INQ000182581**). This largely repeated the findings of the 22 March 2021 report (above): appropriate arrangements had been put in place by health boards to oversee the safe implementation of their vaccine programmes, with positive examples of the safe management of vaccines, good infection prevention and control measures and safe care provided to patients by dedicated staff. Some improvements were required, in the areas set out in the 22 March 2021 report, and without exception the relevant health boards were prompt and effective at resolving the risks HIW had identified.

g) Informal Ministerial Briefing – Healthcare Inspectorate Wales – COVID-19 National Review, dated 23 June 2021(**AGM3WGO01/74 - INQ000182582**). The HIW found that, overall, the quality of care provided across Wales during the pandemic was of a good standard during a hugely challenging period. A key area identified was the need for healthcare services to continue to strengthen their infection prevention and control arrangements in order to mitigate the risk of any future outbreaks of Covid-19. Whilst on a whole infection control had been managed appropriately, the number of outbreaks seen during the second wave illustrated the need to reduce the risk of transmission as much as possible.

Life Sciences Hub

267. Life Sciences Hub is an arm's length body of the Welsh Government. It aims to 'catalyse innovation and collaboration between industry, health, social care and academia'. They work closely with health and social colleagues across Wales to understand the challenges and pressures an organisation may face. Once identified, they work with industry to source and support the development of innovative solutions to respond to these challenges. They currently run four programmes: Digital Health Ecosystem Wales, Accelerate, Intensive Learning Academies Wales and The Academy of Medical Sciences Cross-Sector Programme.

268. In March 2020 the Life Sciences Hub established contact points for various workstreams that they were undertaking which included, medical devices (including ventilators), infection control/point of care testing, digital solutions and social isolation and loneliness. In the early stages of the pandemic there was a groundswell of support from various parts of Wales offering to help to develop PPE and new technology to support NHS Wales tackle the outbreak. The Life Sciences Hub coordinated this support and fed into NWSSP and worked closely with Public Health Wales on diversification of testing in Wales.

Health and Care Research Wales

269. Health and Care Research Wales is a networked organisation which brings together a wide range of partners across NHS Wales, local authorities, universities, research institutions, third sector and others. Its work is led by the Chief Adviser for Research

in the Population Healthcare Directorate, Welsh Government and the Director of Health and Care Research Wales, with a team within the Research and Development Division, Welsh Government which has responsibility for health and social care research policy, strategy and funding. Health and Care Research Wales is accountable, via Research and Development Division and the Chief Medical Officer, to the Minister for Health and Social Services. During the specified period the Wales Covid-19 Evidence Centre was established as part of Health and Care Research Wales. The Evidence Centre aimed to improve the quality and safety of health and social care delivery by ensuring COVID-19 research is timely and applicable to Wales and undertook a range of research for NHS Wales and for the Technical Advisory Group and its sub-groups.

Health Technology Wales

270. Health Technology Wales is a national body working to improve the quality of care in Wales. They collaborate with partners across health, social care and the technology sectors to ensure an all-Wales approach. They are funded by the Welsh Government and hosted within NHS Wales, but independent of both. They cover any technology or model of care and support in health and social care that is not a medicine. For health, this could include medical devices, diagnostics, procedures and psychological therapies. For social care, this could include equipment, or different models for supporting families, children, adults and the workforce.

271. Health Technology Wales worked to support NHS Wales in responding to the pandemic, it was also a collaborating partner of the Wales Covid-19 Evidence Centre. During the pandemic the organisation contributed to Welsh Government committees and task forces, co-authored three pan-European collaborative reviews and provided scientific advice to industry.

Genomics Partnership Wales

272. Genomics Partnerships Wales was founded by the Welsh Government to deliver 'The Genomics for Precision Medicine Strategy'. This strategy was developed by a Welsh Government-led genomics taskforce. The delivery of this plan included interlinkages with the Pathogen Genomics Unit in Public Health Wales. During the pandemic that

relationship continued with both organisations working on Test, Trace, Protect and assisted in brining genomic sciences into our understanding of the pandemic.

Academic partners, including Swansea University

273. NHS Wales worked with a number of academic partners to deliver the response to Covid-19. Welsh Universities at the start of the pandemic worked to provide solutions on medical devices, ventilators, supplies and PPE. This was coordinated by NHS Wales Procurement Service who was also working with industry to provide additional equipment for Wales. A number of Welsh academics also participated in the Technical Advisory Group and its sub-groups working closely with NHS Wales and Welsh Government officials and technical advisors. Additionally modelling SAIL Databank which was part of Swansea University provided an intelligence led approach to Covid-19 data to inform the response.

NHS Wales working with four nations and UK Government departments

274. Four nations work around public health advice to ministers and the Welsh Government was a core feature, not least at a senior NHS Wales clinician level and through the Chief Medical Officer and TAG. This allowed for the sharing of intelligence and for collaboration in critical areas, recognising the number of areas a coordinated approach is desirable and in the best interests of the public. Of course, that does not mean that there were not areas of divergence between nations.

275. For example, PPE for frontline staff was identified early as a requirement to reduce risk to frontline staff. From around April/May 2020 there were increasing calls for mandating facemasks in the community. The Chief Medical Officer kept the evidence under continual review and was strongly supportive of the use of face masks in clinical settings, but we were conscious of the impact this would have on PPE supplies for those in frontline roles in the health and care sectors. At that time globally PPE stocks were in high demand and the priority was ensuring sufficient supplies of medical grade facemask for hospital and care staff. PPE supply chains for health and care workers in Wales, which were not available to the public, were being closely monitored by the Health Countermeasures group and officials were exploring options to supplement the Welsh share of the UK supplies with additional procurement and manufacturing in

Wales. While our stock in Wales was held for health and care workers with separate supply chains via UK agreements, the Chief Medical Officer was conscious there was less clear evidence around face coverings in non-clinical settings coupled with the potential risk of public consumption disrupting to supply chains or driving the price up by increasing in global demand.

276. Additionally, in terms of advice for those shielding from Covid-19 we continued that advice in the summer 2020 longer than in other UK nations following input from the Disability Equality Forum. In terms of the epidemiology information and analysis, Public Health Wales led the way with engagement on behalf of NHS Wales with the other three nations and had close links with Public Health England and subsequently with the UK Health Security Agency.

277. Early in the pandemic NHS Wales via NHS Wales Informatics Service ("NWIS") and primary care colleagues worked with the UK Department of Health and Social Care ("DHSC") on the categories of the highest risk individuals requiring protective shielding. This was essential to ensure the establishment of the Shielding Programme in Wales which was overseen by the Chief Medical Officer office. I will provide further detail on this in later in this statement.

278. The Welsh Ministers also entered into a number of agreements[55] with various UK Government departments and agencies, underpinned by Memorandums of Understanding or Service Level Agreements, all of which entailed close working during this period, these related to testing programme, vaccine procurement and the Covid pass which will be covered in later modules. Extant agreements with the UK government were in place prior to the pandemic for PPE supplies, although there were concerns about the amount of PPE (including but not limited to facemasks) that would be secured via these agreements and the need for supplies to be supplemented by mutual aid within the four nations and by additional procurement and manufacturing within Wales, as detailed later in this statement. Additionally on the 3 April 2020 Welsh Government officials sought approval to work with the UK Government on an order to disapply Competition Act 1998 restrictions from agreements between Welsh NHS bodies and independent healthcare providers to manage Covid-19. Amendments the

[55] Using powers principally contained in section 83 of the Government of Wales Act 2006.

requirements of the Competition Act were outside of the Welsh devolved powers. Advice was provided to the Minister for Health and Social Services as exhibited in **AGWGO01/75- INQ000097627**. The order subsequently made by the Secretary of State allowed NHS bodies to enter into agreements to procure additional capacity from private providers to manage the COVID-19 outbreak without infringing the Competition Act. The UK Government has made a similar order to disapply Competition Act rules for agreements in England.

Infection Prevention and Control measures during the Covid-19 pandemic

279. The Inquiry requested an overview of the Welsh Government's role in respect of Infection Prevention Control ("IPC"). IPC is a broad area which covers guidance on hand hygiene, personal protective equipment, testing and isolation of infected individuals among other measures all aimed at preventing or reducing the transmission of infective diseases. Given the scope of this topic I have sought information and support from Chris Jones, the Deputy Chief Medical Office ("DCMO(W)").

280. Minimising nosocomial transmission was a key priority throughout the pandemic in both health and social care settings. It is imperative we take every opportunity to reflect and learn from the effects of the pandemic. In January 2022 the Minister for Health and Social Services agreed funding of £9 million to deliver a comprehensive national programme of work to investigate and learn from cases of healthcare acquired Covid-19. Learning emerging from the programme to date is providing extremely valuable insight that will improve the quality and safety of our healthcare services. The £9 million was split into £4.54m per year over two years to support health boards and the NHS Delivery Unit to take forward an important and complex programme of investigation work into cases of hospital-acquired Covid-19. NHS Wales has developed and published a unique national framework (as exhibited in **AGM3WGO01/76-INQ000116737)** in relation to patient safety incidents of hospital acquired Covid-19. The framework sets out the actions health boards should take in response to cases of hospital-acquired Covid-19 in relation to incident reporting, investigation and associated communications.

281. The NHS Delivery Unit oversees delivery of the framework and support health boards in increasing the pace of implementation. NHS Wales has published its

National Nosocomial COVID-19 Programme Interim Learning Report in March 2023, providing an overview of the programme and identifying some of the early learning themes emerging through the programme. A copy of this is exhibited in **AGM3WGO01/77 - INQ000413883[56].** Some of the early learning themes have been categorised as follows:

a) People's experiences

b) Bereavement support and care-after-death services

c) Supporting the service user during the investigation process

d) Visiting restrictions.

e) Patient safety incidents and concerns

f) Patient safety incidents outside of NHS Wales hospitals

g) Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident

h) Application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

i) National infection prevention and control guidance

j) Roll out of guidance

k) Outbreak management

282. In 2024 at the end of the programme the NHS Wales Delivery Unit will publish an end of programme national report. Individual organisations will also publish their own reports in line with reporting requirements. This had not been received at the time of signing this statement.

Formulation of infection prevention and control guidance, protocols or standards

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

283. During all phases of the Covid-19 pandemic, 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 (Northern Ireland, Public Health Scotland, UK Health Security Agency ("UKHSA") and NHS England – also referred to as the 'UK IPC Cell'.

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

285. The IPC guidance for the UK, including Wales, was issued by the UK Government on the 10 January 2020 and based on the limited information available at that time about the coronavirus. The CMO(W) wrote out to all clinical staff in Wales on the 24 January 2020 providing a link to the UK Government website where the IPC guidance was located. A copy of this letter is provided in exhibit **AGM3WGO01/78 - INQ000224481**[57]. This guidance was updated throughout the pandemic period. The Welsh Government did not keep a log of the updates or changes to the guidance as this was held by the UKG Government.

286. All healthcare workers managing possible and confirmed cases were advised to follow the UK IPC guidance for Covid-19. This guidance included instructions about different PPE ensembles that were appropriate for different clinical scenarios. As outlined above the UK IPC Cell would assess international evidence and the guidance and subsequent updates took into to account steps being taken in other countries.

287. In March 2020 the guidance was broadly consistent with the World Health Organisation ("WHO") guidance, with the only difference between the UK IPC guidance and the WHO guidance being the recommendation to use aprons rather than gowns for droplet and contact precautions and the use of FFP3 masks rather than N95

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

or FFP2 masks for aerosol generating procedures. The apron recommendation in the UK was a longstanding recommendation for this transmission route and based on the requirement to be 'bare below the elbows' to enable effective high hand hygiene which was a key measure in reducing the spread of the virus. The use of FFP3 masks was a specification in excess of that recommended by the WHO.

288. The UK IPC Cell kept the guidance under continuous review in line with the emerging evidence/science and data. In November 2021 the UK CMOs and nursing officers asked the UK IPC cell, then chaired by Dr Eleri Davies of Public Health Wales, to review evidence around the route of transmission. A copy of this commission is exhibited in **AGM3WGO01/79 - INQ000227346.** Consequently, a consensus statement by UK Senior Clinicians was published on 17 December 2021 and concluded that the mode of transmission of coronavirus had not changed during the pandemic.

289. Another source of guidance and oversight of IPC measures was via the Nosocomial Transmission Group ("NTG"). The DCMO(W) and the Chief Nursing Officer for Wales ("CNO(W)"), established the NTG in May 2020 with the first meeting held on the 19 May 2020. The NTG membership was drawn from the Welsh Government, Public Health Wales and colleagues from health, social care and professional organisations. The group was stood down on the 28 March 2022.

290. The purpose of the NTG was to provide advice, guidance and leadership for all healthcare and care settings including hospitals, primary and community care, registered care homes, domiciliary care, learning disability units and prisons (healthcare settings) to minimise nosocomial transmission and enable the safe resumption of services.

291. The NTG and Nosocomial Policy team worked with stakeholders to develop a range of guidance, including on implementing IPC, PPE, Covid-19 testing, cleaning standards, bed spacing, ventilation and environmental controls.

292. A list of 'Guidance issued in association with Nosocomial Transmission Group work' is provided in exhibit **AGM3WGO01/80 - INQ000227417**. A number of these documents

were issued jointly or wholly by agencies such as Public Health Wales and NWSSP rather than the Welsh Government.

293. The NTG provided regular updates to the CMO(W) and the Covid-19 Planning and Response group, which assessed the implementation of the IPC measures in Wales. A copy of the update report issued on 15 November 2020 is exhibited in **AGM3WGO01/81 - INQ000396261.** This report showed that hospital transmission rates in Wales had increased over the past weeks as community transmission increased. Evidence suggested that the proper use of PPE limited transmission between staff and patients, but that transmission was occurring between patients and between staff, with the latter caused by a lack of social distancing in non-clinical areas. Data was not collected from care homes in the same way, but many care homes had reported positive Covid-19 results for either staff or residents in the previous 28 days. The report proposed a number of measures for hospitals including routine regular testing of NHS staff, re-testing of unscheduled care patients after five days, a review of hospital discharge guidance, strengthened requirements on bed spacing and environmental controls, encouraging the use of field hospital to enable isolation and segregation of patients, revised cleaning standards and supportive communication to staff. Proposals made in respect of care homes and hospices included a rapid pilot of care home visitor testing before a possible early national roll out, the implementation of prevalence related staff testing for hospices as in care homes, an evaluation of visitor pods for care home visits, and the development of infection prevention and control training for care home visitors.

294. A further report was issued 18 February 2021 which is exhibited in **AGM3WGO01/82 - INQ000227307**, noting that minimising nosocomial transmission was an ongoing challenge for the NHS and care homes in Wales. Nosocomial transmission was widespread in hospitals across Wales. Confirmed cases in staff or residents in care homes were higher during the second wave, peaking in early January 2021 followed by a notable fall. A guidance framework was being identified to accompany the revised testing strategy to identify opportunities for testing patients and preventing Covid-19 from entering and spreading within hospitals. Work was also being undertaken to increase testing on admission and patient vaccination, improve outbreak management, utilise behavioural insight work to reduce staff transmission, strengthen

the implementation of environmental controls and cleaning standards, provide robust advice on PPE, share learning regarding in-hospital transmission, ensure consistency in reporting and investigating nosocomial transmission, finalise care home cleaning standards, support testing for visiting professionals to care homes and to support care homes with infection prevention and control work.

295. Updates were also provided to the NHS Leadership Board, a copy of a paper issued in October 2021 is exhibited in **AGM3WGO01/83 - INQ000227385**. This reported that nosocomial transmission cases made up just 1% of total cases but 39% of total Covid-19 hospital in-patients. Most instances of in-hospital transmission continued to be between staff or between patients, rather than from staff to patients. Nosocomial transmission cases appeared to be higher than in Scotland, with the reasons for this unclear and subject to continued investigation. Comparison with England was problematic due to marked differences in definitions and testing regimes. The Nosocomial Transmission Group and policy team was focused on issuing revised guidance and ensuring support for health and social care, including the publication of guidance for health boards and trusts in September 2021, input into revised UK IPC guidance, review and revision of patient and staff testing guidance, updated guidance on ventilation of enclosed spaces and an urgent review of the requirement to repeat test inpatients at five-day intervals.

Guidance on individual-based IPC measures in healthcare settings

296. As outlined in Part A of this statement, it is important to note that the Health and Social Services Group also provided guidance to social care settings. The scope of the Inquiry's request is currently limited to healthcare settings and that is what I will outline in this section of the statement but IPC measures in social care settings was also an important part of the work undertaken by the Health and Social Services Group during this time.

297. In terms of how the guidance was applied in each of the four nations there was inevitably differences to account for the local structures and organisations but the principles that we adhered to, and directed others to adhere to, were the same across the UK.

298. On the 31 January 2020 the CMO(W) public health link sent to NHS bodies in Wales noted that Public Health England, in collaboration with the NHS, had published *Novel coronavirus (2019-nCoV) infection prevention and control guidance*. A copy of the public health link is exhibited in **AGM3WGO01/84 - INQ000048560.**

299. On the 4 February 2020 the CMO(W) wrote to all the Health Board HCID Leads and Emergency Planning Leads as well as the Chief Executives and Directors of Public Health highlighting that it was important that staff assessing and managing these patients are protected in accordance with Public Health England's guidance. A copy of this letter is exhibited in **AGM3WGO01/85 - INQ000226920.**

300. One particular form of IPC was of course testing. The approach to testing and TTP was no different and advice was based on the latest clinical and scientific evidence at the time, including advice from Public Health Wales, SAGE, TAC/TAG in relation to how we utilised the testing capacity available. Throughout the pandemic, the situation continuously evolved, rapidly especially in the early stages. More evidence and data increased as time passed and the testing capacity significantly increased as well as new technology, consideration of this was on-going and as a result the evolution and adaption of policy and operational delivery continued.

301. Public Health Wales played an important role in this. The Welsh Government held weekly and subsequently fortnightly operational meetings with the testing leads from each health board where forthcoming policy changes were discussed, and we received feedback as to feasibility of implementation. From August 2020, the policy of testing health and social care staff was monitored through discussions in the Testing Clinical Advisory and Prioritisation Group ("TCAP") (a sub-group of TAG established in December 2020) and joint meetings with the nosocomial groups and by reviewing the numbers of tests ordered by settings through the organisational portal.

302. Public Health Wales provided advice on testing which in summary recommended testing of both patients and Health Care Workers ("HCW") and others, if recommended by health board Medical Directors. The HCW involved those in frontline patient facing clinical care working in the following units:

    i. Acute Medical Assessment Units

ii. Emergency Departments

iii. Critical Care Units/Intensive Care Units

iv. Primary Care

v. EMS frontline NHS Ambulance staff.

303. This advice was communicated to the NHS in Wales via the CMO(W). A copy of the CMO(W) letter is exhibited at **AGM3WGO01/86 - INQ000048570**. The CMO(W) noted that keeping HCW off work for 7 days following the onset of symptoms pending a negative result will be detrimental to the safe running of the service compared to providing negative results at day 2 or 3 to allow them to return to work. The CMO(W) noted in his letter that while a negative test does not rule out infection with Covid-19, it provides a basis for early return of HCW from self-isolation to support the running of the service. HCW who test positive and recover from the infection could also be redeployed to care for Covid-19 patients. The Minister for Health and Social Services issued a statement confirming this on the 18 March 2020, a copy of which is exhibited in **AGM3WGO01/87 - INQ000198641.**

304. The testing plan published on 7 April, subsequently set out a number of testing approaches to be delivered in a blended, scaled way to maximise impact. This included aspects such as blood tests for patients, front line staff to monitor acquired immunity and developing point of care testing to control future outbreaks. A copy of this plan is exhibited in **AGM3WGO01/88- INQ000227014**.

305. A critical worker policy was published 18 April 2020, which prioritised testing for critical workers (including those from non-healthcare sectors), based on evidence and best use of testing capacity available at that time. A copy of this policy is exhibited in **AGM3WGO01/89 - INQ000182402**.

306. On the 4 May 2020 Public Health Wales published its Public Health Protection Response Plan. A copy of this plan is exhibited in **AGM3WGO01/90 - INQ000182417.** It was written to support the Welsh Government's 'Leading Wales out of the

coronavirus pandemic: A framework for recovery'[58]. The Public Health Wales Plan assumed that transmission of Covid-19 would continue until mass immunisation was available or there was enough acquired immunity in our population. This plan set out the guidance for testing and for the establishment of contact tracing in Wales. It stated that an enhanced sampling and testing process needed to be integrated into the response plan for the next stage of the pandemic and identified the priorities for testing: diagnosis of symptomatic hospital patients; healthcare / social care management including infection, prevention and control; testing to inform risk assessment of symptomatic general or specified populations and public health control actions including contact tracing; testing for surveillance; and critical worker testing. It gave detailed guidance on the four stages of the testing process (test requesting, sampling, laboratory testing and reporting of results) and highlighted the need to learn from current challenges, recommending that a National Sampling and Testing Group be established.

307. On the 15 July 2020 a New Testing Strategy Published, a copy of which is exhibited in **AGM3WGO01/91 - INQ000275673.** The strategy included a section (4) dedicated to protecting the NHS. It set out approaches to testing patients, for emergency and elective admission, inpatients, outpatients, and discharge; and staff, covering health and care staff and across community, primary and secondary care settings. The strategy was based on TAC's Consensus paper on RT-PCR released on 10 July 2020 and informed by the work of SAGE and its subgroups, along with the seven principles set out by the Royal College of Pathologists. A copy of this paper is exhibited in **AGM3WGO01/92 - INQ000066281**.

308. The strategy stated the following in relation to patients:

    a) Emergency Admissions: all patients will be tested on admission. For patients who test negative, further testing will be undertaken if Covid-19 symptoms are present or develop.

    b) Elective Admissions: when prevalence in the community is high there is merit in providing testing for elective admissions (including day surgery), where patients

[58] As exhibited above in AGM3WGO01/44- INQ000182406

will be required to self-isolate and pre-admission testing undertaken (conducted a maximum of 72 hours in advance), this will take into account the type of procedure or treatment to be undertaken.

c) Outpatients / diagnostic interventions: utilise testing and isolation which will be determined, based on patient and procedural risk. When using the test to inform discharge for individuals whose symptoms of Covid-19 have improved, then a negative RT_PCR, taken 14 days after onset and/ or a detectable antibody level is consistent with an absence of infectivity.

d) Discharge: all patients being discharged to a care home or a hospice will continue to be tested prior to discharge to ensure that they do not transmit the virus into closed settings.

309. In relation to staff, the strategy provided that additional available NHS testing capacity would be used to routinely and strategically test asymptomatic frontline staff as part of infection prevention and control measures, and that antibody tests would be used with healthcare staff to help understand the spread of the disease within healthcare settings.

310. In relation to health and care staff in the community, the strategy stated that the Welsh Government would work with local health boards and local authorities to utilise antibody testing for health and care staff who were accessing people's homes, shielding or attending closed settings, such as care homes, substance misuse and mental health services, shelters or schools.

311. In relation to care homes, the strategy's approach was to:

a) Test all care home staff on a weekly cycle and provide continued access to a dedicated care home portal.

b) Target where there are any new cases and act immediately, include deployment of mobile testing units to test all residents in care homes in cases where a positive test is found.

c) For surveillance, use antibody tests with a sample of social care staff.

312. In relation to asymptomatic testing, the strategy noted that local health boards should consider the following groups in particular:

a) Workforce settings that hold greater risk to the virus spreading, particularly within occupations which involve working very closely with and risk exposure to disease on a daily basis.

b) Risks for Black, Asian and minority ethnic workforces, older workforces and high-risk professions.

c) Settings which hold many vulnerable people which are at inherently high risk, including residents within shared accommodation and community based services in high risk settings: supported housing, homelessness hostels, prisons, refuge accommodation (including Drug and Alcohol Centers), Immigration Centers, Mental Health Secure Units and Learning Disability Shared Accommodation.

313. In light of capacity constraints due to rising infection rates and demand for testing amongst the public during September 2020 the Minister for Health and Social Services, set out the prioritisation for Covid-19 testing in Wales. The six priorities for testing were:

1. tests for NHS clinical care (hospital patients);

2. those living and working in care homes;

3. test NHS staff including GPs and pharmacists;

4. testing to manage outbreaks;

5. those working in education or childcare settings; and

6. all symptomatic individuals.

314. Although the prioritisation was very similar, it differed from UK Government, where priority six – testing the general public - was split into two in England and prioritised depending on whether they lived in an area with high positivity or not. Wales did not

differentiate in this way, because it would be likely that evidence of emerging risk would be missed, which would lead to more areas becoming a concern which in turn could eventually increase the testing needs under priority 4 as part of incidents and outbreaks; and if needed, the Welsh Government would have put further prioritisation of the general public in place. A copy of the advice to the Minister for Health and Social Services on testing prioritisation is exhibited in **AGM3WGO01/93 - INQ000116654**.

315. On the 28 September 2020 I issued guidance on 'COVID-19: Mandatory wearing of face coverings in shops and other indoor public spaces in Wales' by letter and set out the requirement, following the change to regulations on the 14 September and based on Public Health Wales advice, for staff and visitors to health and social care facilities to wear face coverings and masks. A copy of my letter is exhibited in **AGM3WGO01/94 - INQ000392008**[59]**.**

316. In December 2020, following scientific validation of testing using Lateral Flow Test devices, the Minister for Health and Social Services announced the introduction of a programme of regular, twice per week, asymptomatic testing of patient-facing health and social care workers in hospitals and primary care and community care settings, and others who have contact with people in those settings. This testing programme included testing of staff delivering domiciliary care services and professionals visiting care homes and other social care settings. A copy of the advice to the Minister for Health and Social Services is exhibited in **AGM3WGO01/95 - INQ000144929**. The incremental roll-out of this policy began on 14 December 2020.

317. The testing strategy was refreshed and published on 28 January 2021 – which included the following priorities: test to diagnose, test to safeguard, test to find, test to maintain, and test to enable. A copy of the strategy is exhibited in **AGM3WGO01/96- INQ000227387** and the written statement is exhibited in **AGM3WGO01/97 - INQ000227389**.

[59] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227252]

318. Under test to safeguard, workforce testing in health and social care and for staff working with the more vulnerable including settings such as special schools was rolled-out, involving around 160,000 staff having access to twice weekly lateral flow tests.

319. Under test to diagnose, patients were tested on admission to hospital, while in hospital, patients who developed symptoms were tested and asymptomatic in-patients were tested five days after admission and planned admissions to protect patients who are at increased risk.

320. On the 9 March 2021 the 'Framework for testing hospital patients' was published. A copy of this Framework is exhibited in **AGM3WGO01/98 - INQ000081893** and the advice to the Minister for Health and Social Services is exhibited in **AGM3WGO01/99-INQ000136845**. This Framework was developed through the NTG and identified five purposes of testing, building upon the 'testing to diagnose' element of the testing strategy referred to above. The five purposes, set out for the first time in this Framework, were:

    i. to prevent Covid-19 in elective pathways by undertaking pre-admission testing in all patients due to be admitted for elective treatment;
    ii. to prevent Covid-19 in elective pathways in those with previous Covid-19 infection;
    iii. to identify Covid-19 in emergency care pathways, including the use of lateral flow devices or suitable rapid point of care tests, in addition to PCR testing;
    iv. to reduce risk to patients at higher risk, including the consideration of enhanced testing of patients who are extremely vulnerable, receiving dialysis or cancer care; and
    v. to show non-infectivity prior to transfer or discharge of patients with a history of Covid-19.

321. The Autumn and Winter Testing Plan was published in October 2021 outlining that the plan complemented contract tracing priorities and supported the overall scope and purpose of TTP: to minimise or alleviate harm from Covid-19 focusing on harm from an overwhelmed NHS and social care system, maintaining testing capacity and infrastructure to enable continuation of to test to diagnose, test to safeguard, test to

find and test to maintain including extending access to lateral flow tests via community collect, direct and workplaces to 31 December 2021; the intention that the plan forms the basis of the testing elements to be included in the wider winter plans and control plans for Wales'. The advice to the Minister for Health and Social Services on this plan is exhibited in **AGM3WGO01/100- INQ000116698** and a copy of this plan is exhibited in **AGM3WGO01/101- INQ000082368.**

322. On the 22 November 2021 Public Health Wales issued Standard Operating Procedures (SOP), a copy of which is exhibited in **AGM3WGO01/102 - INQ000227384.** This SOP is for the Health Protection System in Wales and follows the principles set out in the Communicable Disease Control Plan for Wales. The Health Protection System is a collaboration between Public Health Wales, the twenty-two local authorities, and the seven health boards in Wales. The SOP clarifies the public health actions required in response to incidents/outbreaks of acute respiratory infection ("ARI") (including Covid-19) in care settings in Wales.

323. On the 1 February 2022 Judith Paget, wrote to the Chief Executives of the NHS bodies in Wales to request that they continue to adhere to the UK Infection Prevention and Control (IPC) guidance, a copy of which is exhibited in **AGM3WGO01/103 - INQ000227358.**

324. In June 2022 the Testing Transition Plan, as exhibited in **AGM3WGO01/104 - INQ000227376** confirmed that testing would continue to be in place for the following groups:

    i. LFD and PCR testing for those eligible for Covid-19 treatments.

    ii. PCR testing for COVID-19 and other respiratory viruses for symptomatic care home residents and prisoners.

    iii. PCR and LFD testing under the patient testing framework and when clinically advised including pre-operative hospital patients and care home residents returning from inpatient hospital stays.

    iv. LFD testing for symptomatic health and social care staff.

v. Twice weekly LFD tests for asymptomatic testing for health and social care staff.

vi. Those visiting people in care homes should continue to test using tests provided by the care home they are visiting.

325. The Minister for Health and Social Services announced this in a written statement issued on 24 June 2022 as exhibited in **AGM3WGO01/105- INQ000227373.** The position remained until 8 September 2022 from which time changes to our testing arrangements in health and social care were introduced so that there was a pause in regular asymptomatic testing of staff in the following settings:

i. the NHS (including independent healthcare providers treating NHS patients)

ii. social care settings, including care homes and hospice services

iii. special schools

iv. and paused asymptomatic testing for visitors to care homes, visitors to those eligible for Covid-19 treatments and prisoners on admission to prisons.

Use of scientific evidence to inform changes in infection prevention and control measures

326. In the Welsh Government our approach to any policy is to work in collaboration with key stakeholders, using through relevant and up to date evidence and research (including that of Public Health Wales, TAC and SAGE) to provide advice to ministers on the policy in question through formal, routine advice procedures. The Welsh Ministers' role is then to agree and set the policy direction, bring together partners and coordinate activity across Wales, and also agreeing funding. Throughout this period, we were largely reliant on information from Public Health Wales as to the most effective measures to prevent or control Covid-19 infections. The advice and evidence form the basis of the policy and subsequent workstreams, where stakeholders work together, and partners deliver the programmes of work operationally. Stakeholders in Wales included officials across Welsh Government, Public Health Wales, TAC, Life Sciences Hub, Health Technology Wales, Shared Services Partnerships, NHS Wales

Informatics Service ("NWIS") (which is now part of Digital Health Care Wales ("DCHW").

327. Initially Public Health Wales issued updates on coronavirus to Health Protection Teams, Microbiologists, local health boards, GP, Welsh Ambulance Service, Port Authorities and the Welsh Government, as exhibited in the following documents:

    a) 8 January 2020 - **AGM3WGO01/106 - INQ000191859**[60]

    b) 10 January 2020 - **AGM3WGO01/107 - INQ000283269**[61]

    c) 23 January 2020 - **AGM3WGO01/108 - INQ000283270**[62]**.**

328. These advice updates referred health boards and trusts to the Public Health England IPC guidance. After this time the Chief Medical Officer office issued Public Health Links on the virus which included advice on the IPC measures for health care providers directing health boards and NHS trust to the Public Health England IPC guidance. As outlined above, subsequent guidance for IPC in Wales was issued jointly with the 'UK IPC Cell', which Public Health Wales was a member of, and was based on a continuous review of the international evidence base.

329. In respect of some of the other IPC measures outlined above such as testing and TTP advice was based on the latest clinical and scientific evidence at the time, including advice from Public Health Wales, SAGE, TAC/TAG in relation to how we utilised the testing capacity available. Advice from these organisations on testing and TTP is set out below:

    a) Public Health Wales Public Health Response Plan as exhibited above in AGM3WGO01/88 - INQ000182417.

    b) TAG advice on RT-PCR released on 10 July 2020 and informed by the work of SAGE and its subgroups, along with the seven principles set out by the Royal

[60] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000320698]
[61] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000352946]
[62] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000352948]

College of Pathologists. A copy of this paper is exhibited above in AGM3WGO01/90 - INQ000066281.

c) SAGE advice on the potential impact of behavioural and social interventions on a Covid-19 epidemic in the UK as exhibited in **AGM3WGO01/109 - INQ000252037**[63] and the Principles for the design of behavioural and social interventions, as exhibited in **AGM3WGO01/110 - INQ000148834**[64].

330. Throughout the pandemic, the situation continuously evolved, rapidly especially in the early stages. More evidence and data increased as time passed and the testing capacity significantly increased as well as new technology, consideration of this was on-going and as a result the evolution and adaption of policy and operational delivery continued.

Personal Protective Equipment

331. The provision of appropriate and high-quality personal protective equipment ("PPE") was undoubtedly one of the most significant challenges in ensuring the safety and wellbeing of the health care workforce. As outlined in Part A of this statement, while Module 3 is focussed on health care systems we do have an integrated health and social care system in Wales. The Welsh Government, via NWSSP, also took steps to ensure the provision of PPE to social care settings during the pandemic period. This was consistent with our stockpile of PPE for pandemic influenza also taking account of consideration of the social care workforce as well as NHS staff.

332. During the pandemic period PPE was sourced in Wales from pre-existing arrangements which operated on a four nations basis in which Public Health England acting on behalf of the Secretary of State for Health was responsible for sourcing PPE.

333. In accordance with the agreement made under the UK Pandemic Influenza Strategy 2011 (AGM3WGO01/25- INQ000177116), the Welsh Government maintains a range of medical countermeasures and consumables to deliver what the 2011 strategy

[63] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000281644]
[64] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000299221]

termed "a defence-in-depth" pandemic response. The Welsh Government is part of a UK health countermeasures structure that maintains these countermeasures in a state of readiness. All four UK nations hold stockpiles of antivirals, antibiotics, consumables and personal protection equipment for front line health and social care staff.

334. A Memorandum of Understanding ("MOU") was entered into on the 18 July 2018 between the devolved governments and the Secretary of State for Health (acting via Public Health England) in relation to the provision of procurement, storage and distribution services forming part of the Pandemic Influenza Preparedness Programme ("PIPP") and the Emergency Preparedness Resilience and Response ("EPRR") Programme. Included in the MOU is the procurement, storage and distribution of consumables which broadly include surgical facemasks, eye protection, liquid hand soap, aprons and gloves (PPE). A copy of this MOU is exhibited in **AGM3WGO01/111 - INQ000177454.** When I refer to a "four nations basis" in relation to PPE I am referring to these arrangements.

335. Under the MOU, the UK acts as lead purchaser and undertakes procurement exercises on behalf of the four nations to ensure value for money and to enable governments to benefit from economies of scale. On the 10 December 2019 the Minister for Health and Social Services agreed to the continuation of the MOU to 2025 with Public Health England and other devolved administrations on a four-nation approach to the procurement and distribution of medicines and health emergency countermeasures. A copy of the Ministerial Advice on the continuation of this agreement is exhibited in **AGM3WGO01/112 - INQ000177473**.

336. Where possible, Wales proportion of health countermeasures are stored in Wales. It is stored in a new, modern, secure location owned by the Welsh Government, and maintained under a Service Level Agreement with NWSSP (Procurement). A copy of this agreement is provided in exhibit **AGM3WGO01/113 - INQ000204701**. This ensured that the stocks could be made available quickly in the event of a pandemic. It also provided value for money benefits through reduced rental and maintenance costs. Due to the scale of countermeasures stock managed during the pandemic additional storage facilities were also used.

337. In Wales this was supplemented by NWSSP who procured additional PPE and distributed PPE in Wales on behalf of the Welsh Government. At the onset of the Covid-19 pandemic, NWSSP rapidly expanded their existing NHS-only supply and distribution process for health boards, to one delivering across numerous settings. From March 2020 NWSSP were also requested to expand operations in order to supply local authorities with PPE for onward distribution to the social care sector, as well as delivering to primary care settings including GPs, pharmacists, and dental and optometry contractors. These additional arrangements were put in place in response to mounting concerns regarding the availability of PPE, as outlined by the Minister for Health and Social Services in a statement as exhibited in **AGM3WGO01/114-INQ000383574**.

338. The Welsh Government, working closely with NWSSP to whom we must give a significant amount of credit, retained national supplies in the most difficult of circumstances. At times, however, we were under considerable pressure with local supplies running down to the last few days of supply. While there were always plans for additional sources the risks and implications of running out of appropriate PPE weighed considerably on the local health and social care sectors. We worked to build up confidence over time by transparency of available supplies and stocks to reassure local concerns and to enable them to plan local deployment. Welsh Government mitigation plans included improving modelling on PPE demand, onboarding new suppliers with quality testing, working with potential Welsh manufacturers of PPE, improving data on the stocks held by local health boards and, on a four nations basis, mutual aid across the four nations. The national effort for PPE supplies was a matter to be proud of but should not minimise or take away from the very real and pressing concerns of local teams in health and care settings.

Pre-Pandemic Stock Supplies

339. The pandemic influenza stockpile of PPE products agreed as part of this four nations approach would be in addition to any PPE procured and distributed by NWSSP as part of business-as-usual requirements and any PPE purchased by healthcare organisations themselves.

340. The Welsh Government Health Countermeasure Group provided oversight of the national countermeasure stockpiles for pandemic influenza and Chemical, Biological Radiation and Nuclear ("CBRN") threats. The Welsh pandemic influenza preparedness ("PIP") stockpile included antiviral medicines, antibiotics, intravenous fluids, a range of medical consumables and PPE (including surgical masks, eye protection, liquid hand soap, detergent, hand hygiene, clinical waste bags, paper towels, aprons, and gloves). The pandemic influenza stockpile of PPE was crucial during the first 4 months of the COVID response and gained time to enable NWSSP to successfully secure ongoing PPE supplies.

341. From February 2020 members of this group sat as a weekly Covid-19 Health Countermeasures Group. The Group, reporting into the Health and Social Services Group Covid-19 Planning and Response Group, was chaired by the Health Emergency Planning Adviser, and included Shared Services Procurement, pharmacy, and infection control expertise. The Terms of Reference for the Group, as exhibited in **AGM3WGO01/115 - INQ000107110** sets out it purpose as to:

    a. Ensure pandemic stocks are deployed according ministerial agreement.

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

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

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

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

342. Members of the group included:

    a. David Goulding Chair (Welsh Government)

    b. Anne Hinchliffe (Pharmacist, NHS Wales)

    c. Mark Roscrow Deputy Chair (NWSSP)

d. Graham Davies (NWSSP)

e. Tony Chadfield (NWSSP)

f. NR (Public Health Wales)

g. Name Redacted (Welsh Government)

343. This group developed arrangements to distribute pandemic stock to health services when necessary. Oversight and accountability for this work came under the HSS Planning and Response Group chaired by Samia Edmonds, Planning Programme Director. The Welsh Government suspended the Health Countermeasures Group on 1 June 2020 as it was superseded by the PPE Cell referenced below further.

344. In terms of the pre-pandemic stockpile figures before the 1 March 2020, this information would be held by NWSSP. The Health Countermeasures Group received updates on the PPE stock holding. The reports prior to the 9 March 2020 are outlined below:

a) 26 February 2020 - **AGM3WGO01/116- INQ000352951**

b) 4 March 2020 - **AGM3WGO01/117 – INQ000352953**

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

Table 2 – PPE Stock as at 4 March 2020

Item description	In date stock held	Out of date stock held	Total stock held
APRON DISPOSABLE POLYTHENE (ROLL 200)	45,649	0	45,649
BAG CLINICAL WASTE YELLOW (ROLL 150)	0	0	0
BAG CLINICAL WASTE ORANGE (ROLL 25)	9,919	0	9,919
EYEWEAR: GOOGLES PROTECTIVE FRAMES PG0001F	1,488,000	0	1,488,000

EYEWEAR: GOOGLES PROTECTIVE LENSES PG0001L	1,656,000	0	1,656,000
FACEMASK RESPIRATOR FFP3 UNVALVED: 1863	0	559,080	558,080
FACEMASK RESPIRATOR FFP3 VALVED: 1873V	0	64,680	64,680
FACEMASK RESPIRATOR FFP3 VALVED: 8833	0	246,240	246,240
FACEMASK RESPIRATOR FFP3 VALVED: 8833 (ADDITIONAL FROM NHS ENGLAND)	77,520	0	77,520
FACEMASK TYPE IIR SURGICAL: SFM001	4,906,000	0	4,906,000
GLOVES NITRILE LARGE (PACK OF 200): GN92L	5,490	0	5,490
GLOVES NITRILE MEDIUM (PACK OF 200): GN92M	10,520	0	10,520
GLOVES NITRILE SMALL (PACK OF 200): GN92S	8,060	0	8,060
VENTILATOR ADULT (PNEUPAC)	27	0	27
VENTILATOR CHILD (PNEUPAC)	9	0	9
LIQUID ALCOHOL HAND RUB 0.5L	23,880	0	23,880
LIQUID HAND SOAP (GEL) 0.5L	0	0	0
LIQUID HAND SOAP (FOAM) 0.5L	0	0	0
NEUTRAL DETERGENT 1.0 LITRE (HOSPEC)	13,446	0	13,446
HANDTOWELS 2PLY ZIGZAG FOLDED 23C25CM: MTR041	87,000	0	87,000
SHARPS CONTAINED 22L: DD475YL	1,404	0	1,404
SURGICAL GOWNS	0	0	0

346. Formal reporting of PPE stockpiles and usage commenced on the 9 March 2020. A combined report setting out management information received from NWSSP on PPE items issued during the pandemic period up to 27 March 2022 is exhibited in **AGM3WGO01/118 - INQ000227378**.

347. In addition to the health countermeasures group an 'executive leads group', referred to as the 'PPE cell' met from late April 2020 and brought together a senior officer from the Welsh Government, Alan Brace (Director of Finance), and representatives from NWSSP, each health board, Velindre NHS Trust, WAST and Public Health Wales to exchange information on local issues and the national response. This group initially supplemented the Covid-19 health counter measures group referred to above and

replaced it from June 2020. The creation of a standalone cell and having an executive director chairing the group provided prominence and leadership to ensure appropriate focus.

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

349. The Welsh Government also worked closely with the Welsh Local Government Association via a Covid-19 procurement working group which was established in March 2020. NWSSP joined this group in April 2020 ensuring a joined-up approach to procurement of PPE across health and social care in Wales.

350. The Cell reported into me regularly and also provided assurance to the Minister for Health and Social Services. Additionally, due to the nature of the work it was leading on it also liaised with the Deputy Minister for Economy, Lee Waters to support the Welsh manufacturing of PPE. The manufacturing of PPE and engagement with new suppliers required putting in place appropriate quality control arrangements. To achieve this the Welsh Government worked closely with the Life Sciences Hub and the Surgical Materials Testing Laboratory in Bridgend. These arrangements provided ministers with assurances on the quality and the safe supply of PPE for Wales.

351. To be clear, PPE supplies procured by the Welsh Government were for health and care workers in Wales. Members of the public were not to my knowledge able to access the same supply chain. At the time the Chief Medical Officer did raise concerns about public use medical grade facemasks but this was part of a wider discussion on the use of medical grade face masks and face coverings and did not impact ensuring health and social care workers had access to appropriate PPE.

352. Between March 2020 and March 2022 NWSSP issued over 1.3 billion items of PPE to the health and social care sectors in Wales. About 550 million of these were issued to the social care sector. The data includes PPE procured directly by NWSSP as well as PPE distributed by NWSSP received from the UK Government as part of the four

nations arrangements. The published data includes stock issued from NWSSP only and does not include any stock procured directly by the NHS or local authorities.

The formulation or issue of guidance regarding the use of PPE in the healthcare system

353. Guidance on PPE was agreed jointly between the four UK nations and was set out in the UK PPE Plan and on the UK-wide Covid-19 PPE hub, which included recommendations on the use of PPE for hospital, primary care, community and social care settings, as well as for paramedics. This guidance set out the PPE for staff roles, clinical procedures and settings in the healthcare sector. The guidance also covered how long PPE should be used for and when it should be replaced. The guidance was written and reviewed by all 4 UK public health bodies and informed by NHS infection prevention control experts. The guidance was consistent with World Health Organization ("WHO") guidance for protecting health and social care workers from Covid-19.

354. On the 31 January 2020 the CMO(W) issued a public health link, as previously exhibited in AGM3WGO01/84- INQ000048560 above, sent to NHS bodies in Wales noted that PHE in collaboration with the NHS has published guidance covering the following:

    a. Initial assessment and investigation of cases

    b. Infection prevention and control and guidance

    c. Guidance for diagnostics laboratories

    d. Guidance for primary care

355. The health link noted that four key principles to bear in mind in community settings are to:

    a. Identify possible cases as soon as possible.

    b. Isolate to prevent transmission to other patients and staff.

    c. Avoid direct physical contact unless wearing appropriate personal protective equipment.

d. Get specialist advice from Public Health Wales.

356. On the 18 March 2020 the *Covid-19 preparedness and response: guidance for the health and social care system in Wales* was issued by the Health and Social Services Group Planning and Response Group. A copy of which is exhibited in **AGM3WGO01/119 - INQ000395659.** This guidance was to be read in conjunction with other guidance particularly the *Wales Health and Social Care Influenza Pandemic Preparedness & Response Guidance 2014,* as exhibited above in AGM3WGO01/27 - INQ000116503. The 2014 Influenza Guidance in relation to PPE noted at section 4.4 that *"Although there are central stockpiles of facemasks and respirators, it could take time for distribution of centrally held stocks to be completed and organisations should prepare to rely initially on local stocks and continuity arrangements. For this reason, organisations should maintain sufficient stock for seven days use in the initial stages."*

357. On the 2 April 2020 updated UK wide PPE guidance was agreed by the four UK CMOs, CNOs and Chief Dental Officers in the UK and endorsed by the Academy of Medical Royal Colleges. This guidance was maintained by the UK Government online. Copies of the guidance were shared in advance of publication and is set out in the following exhibits:

a) Covid-19 Infection Prevention and control guidance **AGM3WGO01/120 - INQ000088334**[65]

b) A separate copy of the specific PPE section - **AGM3WGO01/121- INQ000352974**

c) New PPE Guidance for NHS Teams summary - **AGM3WGO01/122 - INQ000336373**

d) Table 3 (reproduced below) – recommended PPE for healthcare workers by secondary care inpatient clinical settings, NHS and independent sector - **AGM3WGO01/123 - INQ000352975**

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

e) Table 4 (reproduced below) – Recommended PPE for primary, outpatient and community care by setting - **AGM3WGO01/124- INQ000352976**

f) Table 5 (reproduced below) – Additional considerations in addition to standard infection prevention and control precautions, where there is sustained transmission of Covid-19 - **AGM3WGO01/125 - INQ000352977**

g) Media Q&A on the guidance **AGM3WGO01/126 - INQ000352980**

358. The guidance set out the PPE for particular staff roles, clinical procedures or settings provided that:

a) Any clinician working in a hospital, primary care or community setting within two metres of a suspected or confirmed Covid-19 patient should wear an apron, gloves, surgical mask and eye protection, based on the risk. Higher levels of protective equipment should be used when carrying out aerosol generating procedures. The full recommendations for PPE usage across different clinical scenarios were set out in new tables reproduced below.
b) In some circumstances PPE, particularly masks and eye protection which is there to protect health and care workers, can be worn for an entire session (without being changed between patients) where it is safe to do so.
c) Re-usable PPE can be used, using suitable decontamination arrangements as per manufacturer instructions.
d) FFP2 and N95 respirators may be used if FFP3 respirators are not available.
e) Hand hygiene should extend to forearms if exposed.

Table 3: Recommended PPE for healthcare workers by secondary care inpatient clinical settings, NHS and independent sector

Table 1. Recommended PPE for healthcare workers by secondary care inpatient clinical setting, NHS and independent sector

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

Setting	Context	Recommended PPE						
		Disposable Gloves	Disposable Plastic Apron	Disposable fluid-resistant gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Acute hospital inpatient and emergency departments, dental and maternity settings	Performing a single aerosol generating procedure[2] on a possible or confirmed case[3] in any setting outside a higher risk acute care area[4]	✓ single use[5]	✗	✓ single use[5]	✗	✗	✓ single use[5]	✓ single use[5]
	Working in a higher risk acute care area[4] with possible or confirmed case(s)[3]	✓ single use[5]	✓ single use[5]	✓ sessional use[6]	✗	✗	✓ sessional use[6]	✓ sessional use[6]
	Working in an inpatient, maternity, radiology area with possible or confirmed case(s)[3] - direct patient care (within 2 metres)	✓ single use[5]	✓ single use[5]	✗	✗	✓ sessional use[6]	✗	✓ sessional use[6]
	Working in an inpatient area with possible or confirmed case(s)[3] (not within 2 metres)	✗	✗	✗	✗	✓ sessional use[6]	✗	✓ risk assess sessional use[6,7]
	Working in an emergency department/acute assessment area with possible or confirmed case(s)[3] - direct patient care (within 2 metres)	✓ single use[5]	✓ single use[5]	✗	✗	✓ sessional use[6]	✗	✓ sessional use[6]
	All individuals transferring possible or confirmed case(s)[3] (within 2 metres)	✓ single use[5]	✓ single use[5]	✗	✗	✓ single or sessional use[5,6]	✗	✓ risk assess single or sessional use[5,6,7]
	Operating theatre with possible or confirmed case(s)[3] -no AGPs[2]	✓ single use[5]	✓ single use[5]	✓ risk assess single use[6,7]	✗	✓ single or sessional use[5,6]	✗	✓ single or sessional use[5,6]
	Labour ward/ area- 2nd/3rd stage labour vaginal delivery (no AGPs[2]) - possible or confirmed case[3]	✓ single use[5]	✓ single use[5]	✓ single use[5]	✗	✓ single or sessional use[5,6]	✗	✓ single or sessional use[5,6]
	Inpatient care to any individuals in the extremely vulnerable group undergoing shielding[8]	✓ single use[5]	✓ single use[5]	✗	✓ single use[5]	✗	✗	✗

1. This may be single or reusable face/eye protection / full face visor or googles
2. The full list of aerosol generating procedures (AGPs) is within the COVID-19 IPC guidance. [note APGs are undergoing a further review at present]
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Higher risk acute areas include: ICU/ HDUs; ED resuscitation areas; wards with non-invasive ventilation; operating theatres; endoscopy units for upper Respiratory, ENT or upper GI endoscopy; and other clinical areas where AGPs are regularly performed.
5. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
6. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/ exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting / exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
7. Risk assessed use refers to utilising PPE when there is an anticipated /likely risk of contamination with splashes, droplets or blood or body fluids.
8. For explanation of shielding and definition of extremely vulnerable groups see guidance: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

Patient use of PPE

In cohort wards, communal waiting areas and during transportation, it is recommended that suspected or confirmed cases wear a surgical face mask if this can be tolerated. The aim of this is to minimise the dispersal of respiratory secretions, reduce both direct transmission risk and environmental contamination. A surgical face mask should NOT be worn by patients if there is potential for their clinical care to be compromised (e.g. when receiving oxygen therapy via a mask)

Table 4: Recommended PPE for primary, outpatient and community care by setting

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

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

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

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

Table 5 : Additional considerations in addition to standard infection prevention and control precautions, where there is sustained transmission of Covid-19

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

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

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

359. The updated guidance reflected the fact that Covid-19 was now widespread in the community, meaning clinicians were more likely to see patients with the virus. The guidance was based on the best scientific evidence and is consistent with what WHO recommends in circumstances and settings with the highest risk of transmission. The CMO(W) wrote out to the NHS in Wales informing them of the update on the 3 April 2020. A copy of this letter is exhibited in **AGM3WGO01/127 - INQ000080942** along with the appendices set out in **AGM3WGO01/128 - INQ000080940, AGM3WGO01/129- INQ000117822**[66] and **AGM3WGO01/130 - INQ000080939.**

360. On the 1 February 2022 Judith Paget, my successor to the role of Director General of the Health and Social Services Group and as Chief Executive NHS Wales, wrote to the Chief Executives of the NHS bodies in Wales to request that they continue to

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

adhere to the UK Infection Prevention and Control (IPC) guidance. A copy of Judith Paget's letter was exhibited in AGM3WGO01/103 - INQ000227358.

Supply of PPE to the healthcare sector

361. The model of distribution of PPE adapted to circumstances as they emerged to ensure products were provided to Wales's NHS, social care, optometrists, dentists, and GPs.

362. Military support was embedded into the Health and Social Services Group Covid-19 Planning and Response arrangements from March 2020 to July 2021. A Military Assessment Team was deployed on 1 – 2 April 2020 to support the Welsh Government by providing an audit of its PPE distribution capability.

363. Request for PPE products by NHS Wales bodies (including hospital and ambulance services) followed the normal procurement requisitioning process utilising the NWSSP oracle system. The Welsh Government was not involved in responding to requests for additional stock at a local level. Emergency requests were channelled through the same process with checks applied to prevent over ordering. Primary Care were linked into these arrangements, as outlined in exhibit **AGM3WGO01/131 - INQ000395690.** Special arrangements were put in place to ensure social care and other healthcare providers were able to access PPE. Health boards also established internal distribution points.

Assessment of the adequacy of the PPE provided to healthcare systems

364. There was a proper procurement process at the UK level ensuring that products complied with the regulatory standards. Regulation (EU) 2016/425 ("the PPE Regulation") required that certain kinds of PPE must be conformity assessed before they could be placed on the market and certified by a conformity assessment body – this is the CE mark on goods and products[67]. PPE in the legislation is defined in accordance with the Personal Protective Equipment at Work Regulations 1992, which specifies as 'all equipment (including clothing affording protection against the weather) which is intended to be worn or held by a person at work and which protects the person against one or more risks to that person's health or safety, and any addition or

[67] The Personal Protective Equipment (Enforcement) Regulations 2018 provide a system for the enforcement of the PPE Regulation in England and Wales.

accessory designed to meet that objective'. The PPE Regulations do not apply to personal protective equipment which is:

a) specifically designed for use by the armed forces or in the maintenance of law and order

b) designed to be used for self-defence, except for PPE intended for sporting activities

c) designed for private use to protect against:

i. atmospheric conditions that are not of an extreme nature

ii. damp and water during dishwashing

d) for exclusive use on seagoing vessels or aircraft that are subject to the relevant international treaties applicable to the UK

e) protective helmets and their visors for drivers and passengers of motorcycles and mopeds.

365. The PPE products in the pandemic influenza stockpile intended to provide such protection was determined at the UK level based on scientific evidence with advice from the New and Emerging Respiratory Virus Threats Advisory Group, which included a PPE subgroup on which Public Health Wales represented Wales.

366. Temporary arrangements were adopted in March 2020 following Commission Recommendation 2020/403 ("the Recommendation") which eased the requirement for a conformity assessment for certain categories of PPE for a limited time to increase the supply of essential Covid-19-related PPE on the UK market generally, and for healthcare workers in particular. From March 2020 to the 31 January 2021 the recommendation applied. In practice, this enabled the NHS and the governments of the UK to procure non-conformity assessed PPE for health and care workers, as long as the PPE met essential health and safety requirements, as approved by Health and Safety Executive ("HSE"). It also permitted PPE which required conformity assessment to be placed on the UK market before the full conformity assessment procedures had been completed and before a conformity mark (i.e "CE" mark) had been affixed. The

conformity assessment procedures were however required to be completed as soon as possible afterwards. Therefore, for all PPE in this period procured or introduced to the UK Market the HSE would have certified that it met essential health and safety requirements.

367. While the PPE Regulation would become retained EU law when the Transition Period ended[68], the Recommendation would lack clarity or legal certainty so equivalent provision needed to be made in domestic law. The Welsh Ministers therefore made the Personal Protective Equipment (Temporary Arrangements) (Coronavirus) (Wales) Regulations 2020 as a consequence of the pandemic and the UK's exit from the European Union. Similar temporary arrangements were made in England to enable faster supply of PPE for Covid-19 use. These Regulations replicated the arrangements set out in the EU Recommendation. In the Regulations the arrangements only applied to "Covid PPE" which was defined as PPE that is necessary for protection against the coronavirus disease; and requires conformity assessment by an approved body, in accordance with Article 19 of the EU PPE Regulation. PPE that was necessary for protection against the coronavirus disease (i.e. Covid PPE in the Regulations) was the PPE recommended by the UK PPE guidance which I have detailed above in tables 3 to 5 above which in summary advised the following for health and care workers:

    a) Surgical Face Masks: HCWs were advised to wear surgical face masks that are correctly fitted and worn while Covid-19 is endemic.
    b) FFP3 and Similar Respirator Masks: For situations where aerosol generating procedures (AGPs) are performed on suspect or confirmed COVID-19 patients, FFP3 respirator masks are recommended. These masks offer higher protection and are crucial during AGPs. FFP2 and N95 respirators may be used if FFP3 respirators are not available.
    c) Apron, gloves, and eye protection.

368. EU PPE Regulation applied to all of the above. It did not apply to non-medical face coverings, such that the public would often have used.

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

369. In Wales NWSSP also collaborated with the Surgical Materials Testing Laboratory in Bridgend who were able to provide expert guidance, assessment and quality assurance on PPE products manufactured in Wales. These products would however also been under the same requirements as set out the summary of the legislation above.

Shortages of suitable PPE in healthcare settings in Wales

370. In Wales while we did not experience a lack of PPE in healthcare settings getting stockpiles to appropriate levels was a pressing concern. There were periods when healthcare organisations noting low levels were asking for PPE products, and while this was responded to appropriately the anxiety felt by healthcare organisations cannot not be diminished.

371. On the 6 March 2020 the Minister for Health and Social Services was asked by officials to agree the release of PPE from the stockpile held for Wales as part of the Influenza Pandemic Preparedness Strategy for use by GPs as soon as possible and for the NHS and social care when needed. Advice to the Minister for Health and Social Services noted concern regarding supply and in particular primary care access to PPE. A copy of this advice is exhibited in **AGM3WGO01/132 - INQ000226928.**

372. On the 9 March 2020 GP surgeries across Wales provided with PPE supplies consisting of face masks, gloves and aprons. Welsh Government also confirmed the release of PPE from stockpile supply for use by frontline NHS and social services staff, should it become necessary.

373. On the 11 March 2020 I wrote to all General Practitioners, Local health boards and the Welsh Ambulance NHS Trust to update on the Covid-19 response. In this letter it noted that primary care practices had indicated difficulty in obtaining sufficient PPE and that as a consequence, PPE was being distributed to all practices and out of hours services that week, boosting the supplies already in place. A copy of my letter was previously exhibited in AGM3WGO01/131 - INQ000395690.

374. On the 17 April 2020 the CMO(W), CNO(W) and Albert Heaney, Director of Social Services and Deputy Director General collectively wrote out to health and social care providers in Wales and copied in the Royal Colleges and British Medical Association

to share guidance issued by the CMO England on 'Considerations for PPE in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic.' This was issued in Wales in accordance with routine practice for MHRA alerts however the letter assured health and social care providers that this information was not being cascaded because we expect interruption in our ability to meet PPE demand in Wales. At that time there was nearly 50 million items of PPE in our central stores with significant new orders arriving in the near future. A copy of this letter is exhibited in **AGM3WGO01/133 - INQ000081011.**

375. The continuous supply of PPE remained a paramount concern throughout the pandemic period. This was a clear part of the infection and prevention control measures, as outlined in the section above, and of the safety measures for key workers, including health and social care staff. Additional measures were put in place to help allay concerns including providing greater visibility of the products available and what was on order. In addition, Deloitte were asked to undertake modelling on future product demands. The Welsh Government's Internal Audit Service undertook a review of the PPE structure within the Welsh Government in December 2020 and confirmed reasonable assurance. A copy of this is exhibited in **AGM3WGO01/134 - INQ000022592.**

376. In April 2021, the Auditor General for Wales issued a report 'Procuring and Supplying PPE for the COVID-19 Pandemic', which provides an independent review of the national efforts to supply health and social care in Wales led by the Welsh Government, working with NWSSP and local government. A copy of this is exhibited in **AGM3WGO01/135 - INQ000214235[69].** The report concluded:

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

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

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

c) Royal College of Nursing and British Medical Association surveys suggested that confidence in the supply of PPE grew shortly after the start of the pandemic but that concerns remained, with some reporting shortages of specific items, a small minority saying at times they had none at all and some reporting wanting a higher level of PPE than required under the guidance.

d) There was no evidence of a priority being given to potential suppliers depending on who referred them.

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

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

377. While the concerns of those on the frontline and the worry of PPE shortages cannot be underplayed, what was clear is the tremendous efforts made in Wales to ensure a continuous supply of PPE. While this did mean that at times in Wales there was surplus PPE (and in those circumstances we agreed to provide mutual aid to other nations),

given the worldwide position on PPE I am proud and grateful to all those who worked to ensure PPE supply.

Medical Equipment and Oximeters

378. The Inquiry has asked for an overview of the Welsh Government's response as it related to the availability, supply and use of medical equipment during the pandemic period. In order to address these questions, I have received support from Chris Jones, Deputy Chief Medical Officer for Wales and Samia Edmonds, NHS Planning Programme Director, both of whom are part of the Health and Social Services Group.

Supply and use of ventilators in Wales

379. I am grateful to those within the NHS and Health and Social Services Group who worked on securing medical equipment such as ventilators during the pandemic period. It was imperative that we responded to what the modelling data was telling us at the time. Working on these modelling assumptions we ensured that additional equipment was sourced which meant that there were no substantial issues in relation to availability of ventilators during the pandemic period.

380. During March 2020 the Welsh Government asked all health boards to provide a breakdown of the equipment currently held which established the baseline position from NHS Wales. Health boards were also asked about their oxygen needs over and above existing capacity. Equipment was secured on loan from the UK Government stocks as well as, particularly in the case of ventilators, being procured via NWSSP.

381. From late March 2020, the Welsh Government's Knowledge and Analytical Service ("KAS") coordinated, with input from NHS Wales, a number of daily (7-day-a-week) data returns to both the Welsh and UK Governments. The scope of the daily dashboard return was varied and grew considerably over time. It initially covered topics such as testing, cases, deaths, ventilators and hospital activity, as outlined above in the section on NHS capacity. It grew to include a range of metrics on care homes, staff absence, shielding, food parcels, school attendance, cancer referrals and more.

382. A Written Statement on critical care capacity and ventilation was issued on 6 April 2020 by the Minister for Health and Social Services, a copy of which is exhibited in **AGM3WGO01/136 - INQ000182395**. The statement included the following:

a) Training had been provided to upskill hundreds of staff who do 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, with this number increasing daily. Current occupancy was 48%, with just over half of occupants having confirmed Covid-19.

d) Wales currently had 415 invasive ventilation ventilators, 349 anesthetic machines with ventilator capacity and 207 non-invasive ventilators. An additional 1,035 ventilators were being procured.

383. Shortly after this announcement I wrote to all health boards on 10 April 2020 setting out the process for the allocation of additional ventilation equipment. A copy of my letter is exhibited in **AGM3WGO01/137 - INQ000395696.** As highlighted in that letter initially the Welsh Government's overriding priority was to distribute equipment fairly and efficiently throughout Wales according to:

a. Clinical need, including anticipated peaks;

b. The need to utilise the equipment within 72 hours;

c. Suitability of equipment;

d. Ideally matched to existing equipment/ventilator models already in use at hospitals;

e. In consideration of O2 infrastructure in hospitals.

384. Regular discussions were held with the critical care network and health boards and regular updates were issued to health boards on ventilator/equipment availability. An example of the daily report for the 30 March 2020 is exhibited in **AGM3WGO01/138-INQ000226992.**

385. There were no incidents in relation to availability of ventilators during the pandemic period.

386. At the start of the pandemic, NHS Wales had 415 ventilators in Welsh hospitals which could provide invasive ventilation. There were a further 349 anaesthetic machines with ventilator capacity and 207 non-invasive ventilators. It is my understanding that anaesthetic machines with ventilator capacity are primarily used during surgeries and procedures where patients need to be anesthetised. They deliver a precise mixture of oxygen and inhalational anesthetic agents (such as sevoflurane or desflurane) to maintain anesthesia during surgery. Their primary goal is to keep the patient unconscious and stable during the procedure. They are not designed for long-term use. Mechanical ventilators however differ in that they are commonly used in intensive care units ("ICUs") to support patients with respiratory failure. ICU ventilators can provide continuous ventilation for extended periods.

387. During 2020 an additional 1,238 ventilators were procured by NHS Wales and through UK arrangements via the Department of Health and Social Care Commercial Leads who were linked in with NWSSP colleagues. This included 450 invasive ventilators via UK arrangements, 270 dual purpose (invasive or non-invasive machines) procured by NHS Wales and 518 non-invasive machines) via UK arrangements. The delivery of the ventilators procured through both the NHS Wales Shared Services and UK arrangements was made available in Wales on a phased basis over a 13 week period from April 2020 onwards, based on the original projection of a peak occurring in June/July.

388. During 2020, 713 additional Continuous Positive Airway Pressure ("CPAP") machines were procured either by NHS Wales or by the UK arrangements outlined above which

included 206 UCL/Mercedes F1 machines as part of the national challenge. Exhibit **AGM3WGO01/139- INQ000227298** refers.

389. I have set out below in paragraphs 416 to 458 information on bed occupancy and bed availability during the relevant period, which includes critical care beds and invasive ventilation bed occupancy and availability.

390. In relation to guidance on the use of ventilators or other equipment in critical care facilities, the Welsh Government worked with the Wales Critical Care and Trauma Network ("WCCTN"). The WCCTN was an established group before the pandemic period with a focus on improving the quality of care for critically ill patients throughout Wales. In March 2020 the WCCTN, in collaboration with the Welsh Intensive Care Society ("WISC") issued guidance to health boards in Wales. A copy of this guidance in exhibited in **AGM3WGO01/140 - INQ000226944.** Key points from the guidance include:

a) Despite anticipated increase in demands, usual critical care standards and clinical decision-making are expected to apply, unless or until such a point that staffing and equipment resources have become seriously restricted.

b) Health boards will need to make decisions regarding: the expansion of critical care facilities, including using ventilators not originally specified for critical care use; the redeployment of non-critical care staff to care for ventilated patients; early identification of patients whose care will not be escalated to ventilation; restricting direct contact access of family members to critically ill patients; local measures to maximise staff safety; staff testing; and steps to help the physical and emotional experience of staff working under extreme circumstances.

c) Consideration of non-invasive respiratory support within critical care is a health board decision and will be dependent on the resources available. However, given the likely demand for invasive ventilation, it is most likely that if non-invasive support is offered, it will be provided within dedicated areas of respiratory and acute medical wards following explicit consideration of escalation status, and attention to infection prevention.

d) Children may need to be looked after in adult intensive care units and vice versa. Staff may be working outside their normal practice and there simply may be no alternative.

391. The Welsh Government also worked with the Wales Renal Network looking at the availability of dialysis facilities including haemodialysis machines and consumables in acute renal settings.

Steps taken by the Welsh Government to increase availability of ventilators and other equipment used to provide care for Covid-19 patients

392. Understanding existing stock and anticipating need was an important part of assessing how best to increase availability of ventilators and other equipment. The Military Liaison Officers were embedded in health boards assisted in the monitoring of a range of matters including ventilator capacity which would reported on as a part of the daily sit rep, an example of which is provided in exhibit **AGM3WGO01/141 - INQ000227008.**

393. The Acute Secondary Care Planning and Response Sub-group remit included oversight of the provision of ventilation devices. A copy of this sub-groups terms of reference and membership is exhibited in **AGM3WGO01/142 - INQ000226959.** In March 2020 this subgroup undertook an assessment of available invasive and non-invasive ventilation devices such as ventilators and CPAP devices, until such time as the NHS Daily Sitrep was able to accommodate more routine reporting of oxygen devices available and in use. This included beds with piped oxygen, oxygen concentrators, oxygen cylinders, and non-invasive ventilation or CPAP devices. A copy of the Sub-group's letter to health boards requesting this information on the 24 March 2020 is exhibited in **AGM3WGO01/143 - INQ000226972.**

394. NWSSP led on the procurement of additional ventilation devices and reported procurement activity to the Subgroup. Any offers of support or new supply received via officials or ministers was passed onto the NWSSP to investigate and where appropriate action. The Subgroup also included National Clinical Leads for Respiratory Medicine and for Critical Care, who provided advice on the appropriateness of procuring different devices based on clinical application of those devices.

395. I wrote out to health boards on the 25 March 2020 to outline the work that was progressing to maximise the number of ventilator units and associated equipment and consumables. A copy of this letter is exhibited in **AGM3WGO01/144 - INQ000226994.** A summary of the collated health board responses on ventilator information was provided to me on the 31 March 2020. A copy of this is exhibited in **AGM3WGO01/145 - INQ000226996.**

396. The Welsh Government supported initiatives to support the manufacture of ventilators such as the participation by the Advanced Manufacturing Research Centre ("AMRC") Cymru in hosting the rapid manufacturing of ventilators as part of a consortium of businesses united under the VentilatorChallengeUK initiative. A copy of the announcement of initiative is provided in **AGM3WGO01/146 - INQ000227020.**

397. The Welsh Government also liaised directly with NWSSP Specialist Estates Services and the British Oxygen Company around prioritising oxygen supplies as well as the provision of significant additional oxygen infrastructure (including Vacuum Insulated Evaporator ("VIE") tanks). Initial indications of oxygen provision in health boards were requested on the 9 April 2020, exhibit **AGM3WGO01/147 - INQ000262275**[70] outlines the summary position in Wales at the time and I have reproduced this below in Table 6 for ease of reference:

[70] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227045]

Table 6: Oxygen provision as at 9 April 2020

Health Board / Site	Current litres per minute for whole hospital	Total Gas Volume (Litres)	Days @ maximum flow rate
Aneurin Bevan	17710	38100000	
GUH	9418	Unknown	0.0
Nevill Hall	834	11550000	9.6
St Woolos / Royal Gwent Hospital	3540	13980000	2.7
Ysbyty Aneurin Bevan	1417	5040000	2.5
YYF	2501	7530000	2.1
BCUHB	9665	65470000	
Abergele Hospital	916	1530000	1.2
Glan Clwyd Hospital	3000	31190000	7.2
Llandudno General Hospital	916	1530000	1.2
Maelor Hospital	3000	20060000	4.6
Ysbyty Gwynedd	1833	11160000	4.2
Cardiff and Vale	4418	37320000	
Llandough	834	8550000	7.1
UHW	3584	28770000	17.9
Cwm Taf Morgannwg	10981	72020000	
Prince Charles	917	10620000	8.0
Princess of Wales	3000	25420000	5.9
Royal Glamorgan	4813	27050000	7.8
YCC	1417	4740000	2.3
YCR	834	4190000	3.5
Hywel Dda UHB	8229	47670000	
Brongalis	2063	11320000	3.8
Glangwilli	1875	10420000	3.9
Prince Philip	1875	10420000	3.9
South Pembrokeshire Hospital	916	1530000	1.2
Withybush	1500	13980000	6.5
Swansea Bay	5792	44520000	
Morriston Hospital	2617	24070000	13.5
Neath Port Talbot Hospital	1875	10030000	3.7
Singleton Hospital	1300	10420000	5.6

398. The Royal Engineers involved worked closely with NWSSP-Specialist Estates Services and the British Oxygen Company in agreeing a clear plan of action to support the drive to build capacity in the NHS. A copy of a report prepared by NWSSP which outlined how the Welsh Government, NHS in Wales and the British Oxygen Company responded to the challenge of oxygen capacity and distribution in Wales is exhibited in **AGM3WGO01/148 - INQ000227170.** The report noted that the anticipated oxygen demand needed to cope with the first surge of Covid-19 patients placed unprecedented pressure on the life critical oxygen infrastructure supporting NHS Wales. It concluded that significant progress was made in improving the oxygen flow capacity across local health boards in Wales, with a 75% increase in oxygen provision achieved despite a number of major challenges. Fourteen recommendations were

made, including for further guidance on oxygen usage to aid demand planning, improving communication and working between UK administrations, local health boards ensuring appropriate engineering resource levels are in place, implementing an oxygen plant register and flow capacity model for real-time usage monitoring and the establishment of an All-Wales Covid-19 Estates Infrastructure Delivery Board responsible for planning, funding and monitoring the delivery of improvements in estates infrastructure in preparation for future Covid-19 surges.

The availability of trained staff for the provision of mechanically ventilated patient care

399. Throughout the period we also had to consider the demands on the workforce and the availability of trained staff working with various medical equipment and during periods of surge. Nurse staffing was continuously adapted and evolved to meet the service needs throughout the pandemic period. The Welsh Government did not hold validated data on what the nursing ratios were during the pandemic period so I am unable to provide a detailed operational overview. As noted below in paragraph 419, until 13 November 2020, data on available critical care beds were reported regardless of whether they could be staffed. From this point only critical care beds that could be staffed should have been reported as 'available'.

400. At the start of the outbreak, the UK Chief Nursing Officers in association with a wide number of nursing professional associations issued guidance in relation to appropriate staffing levels for critical care throughout the various surge levels. A copy of this guidance is exhibited in **AGM3WGO01/149 - INQ000227427.** This states that:

    a) Critical care nurses supporting the redeployed workforce would provide supervision and expertise, would be required to take a teamworking approach rather than a ratio approach to patient care to deal with a surge in patients and would need to be supported by other nurses, doctors and allied health professionals.

    b) The Chief Nursing Officers would support staff in training and the development of skills and knowledge; would support staff to work outside their normal practice area, with rapid blended learning, simulation and direct care education; and would

support a flexible, pragmatic, staged approach to additional capacity in line with national surge escalation plans.

c) Royal Colleges and trade unions would provide expertise with and on behalf of their membership to inform the development and implementation of guidance and ensure professional support and redeployment guidance is offered for nurses supporting the delivery of critical care.

401. The flexible approach to critical care nurse ratios was at the discretion of health boards and was not centrally recorded, and there was no centrally mandated level of training specified for healthcare staff to operate a ventilator or to care for such patients.

402. The Critical care network worked with HEIW and local universities, such as the University of South Wales, to develop critical care competencies such as ventilator use for non-critical care staff in addition to local training provided within health boards. As described above in paragraph 350, training was provided to upskill hundreds of staff who did not normally work in critical care. Steps were also taken where possible to ensure nursing staff were not overburdened with tasks which could be done by others or streamlined. Advice was put to the Minister for Health and Social Services on 22 May 2020 to support the use of pre-prepared sterile medicines in critical care settings. The Advice noted that an estimated 105 hours per day of nursing time was currently being spent on preparing medicines for every 100 occupied critical care beds. It highlighted the advantages of pre-prepared medicines in terms of easing the pressure on nursing resources which would otherwise be spent preparing medicines, reduced risk to patients, reduced waste and improved efficiency. A copy of the advice to the Minister for Health and Social Services is exhibited in **AGM3WGO01/150-INQ000116593.**

403. On the 27 July 2020 Chris Jones, DCMO(W) and Jean White, Chief Nursing Officer for Wales ("CNO(W)") wrote to health boards and the WCCTN, to confirm that the critical care nursing exceptional surge guidance, that had been issued at the start of the pandemic, would be withdrawn in Wales. The letter noted that lessons learnt across the UK relating to the practicality and safety of operating at the higher surge levels/ratios, and the reality that in most cases staffing had not proved to be the liming factor in critical care capacity, had led to a review of the guidance and the decision to

withdraw it. I comment further on the limiting factors at paragraphs 492 below. Health boards were directed to meet the requirements in the Faculty of Intensive Care Medicine's bridging guidance published on 22 May 2020 (phases 1 and 2 in the original guidance). Health boards were also asked to carry out a number of actions including to undertake their own lessons learnt review of how critical care has operated and review existing critical care plans including plans for escalation, to ensure appropriate support was available for staff, to consider levels and requirements of ventilators and other equipment, to consider what capacity could be retained in the short term and to ensure plans were in place to reach 200% capacity within 14 days. A copy of the letter is exhibited in **AGM3WGO01/151 - INQ000227210.**

404. On the 23 November 2020 the CNO(W) wrote to the nurse directors to signpost to the Welsh Intensive Care Society (WICS) and the UK Critical Care Nursing Alliance statements on nurse staffing levels for Covid-19, that nurse-patient ratios should be maintained at a minimum of one trained critical care nurse and one registered healthcare professional for two level 3 beds and one trained critical care nurse and one registered healthcare professional for four level 2 beds. The CNO(W)'s letter asked nursing directors to ensure these ratios were adhered to. A copy of this letter is exhibited in **AGM3WGO01/152 - INQ000262416**[71]**.** For context, level 3 care is commonly referred to as 'intensive care' and would normally (prior to the pandemic) have a nursing ratio of 1 trained critical care nurse to every patient or depending on the severity more nurses. Level 2 care is commonly referred to as 'high dependency' and would normally have a nursing ratio of 1 trained critical care nurse to every two patients.

405. My letter to the Public Accounts Committee dated the 9 December 2020, a copy of which is provided in exhibit **AGM3WGO01/153 - INQ000227278,** provides a contemporaneous and detailed summary of the actions taken in response to questions raised about resourcing of nurses and doctors during 2020, including:

    a) My work to ensure that all NHS boards stood up appropriate governance structures to manage the emergency response locally.

[71] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227280]

b) Details of the actions taken and guidance given in respect of nursing levels and ratios, as described above in my statement.

c) Details of the number of returned nurses and doctors who had been re-employed to alleviate pressure during the pandemic (40 GMC re-registrants and 53 NMC re-registrants, though these figures would not capture those who have since left).

d) The increased focus on more urgent and routine services, as well as Covid-19 and essential services, during the second wave.

The Welsh Government's views on the accuracy of oximeter readings and how this may vary depending on the skin tone of the patient

406. The Welsh Government was aware of the NHS Race and Health Observatory report dated March 2021 relating to pulse oximetry and racial bias. It noted that a growing body of evidence suggested that pulse oximetry is less accurate in darker skinned patients and recommended an urgent review of such devices by the UK Medical and Healthcare Products Regulatory Agency. While the picture on racial bias in pulse oximetry was still mixed, the report said, the worst-case scenario was that it could potentially have negative outcomes for patients with more skin pigmentation. A copy of the report is exhibited in **AGM3WGO01/154 - INQ000249826**[72]**.** This report was posted on the All-Wales Healthcare Science Network Sharepoint for information. The report findings were not however incorporated into the treatment pathways at the time in Wales as it was unclear whether there was sufficient data to support a case for inclusion.

407. This report was recirculated in November 2021 following a BBC news story. Following a request from the Minister for Health and Social Services for more information, the DCMO(W) checked the position with Name Redacted the National Respiratory Lead for Wales. A response to the Minister was provided by email, as exhibited in **AGM3WGO01/155 - INQ000227343** and which noted that there was a documented difference in the effectiveness of visible range light spectra diffusing and reflecting through skin with different melanin levels, there was extensive guidance for account

[72] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227342]

for the difference in skin tone when using oximetry and that UK level guidance was due to come out shortly on this issue.

408. I understand that the TAC provided a brief on this on the 10 February 2022. This referred to concerns around oximeters giving a falsely high reading in patients with Black or Asian ethnicity and that, although the data could not quantify the impact of these errors on clinical are, any resulting delay in appreciating the severity of Covid-19 pneumonitis was likely to be detrimental to patient care. It noted that UK-led review of potential bias in medical devices was currently ongoing and the findings would be published in the next 18 months. A copy of the brief is exhibited in **AGM3WGO01/156-IINQ000087026**. No further action was taken in Wales in respect of this.

The effectiveness of home monitoring using pulse oximetry devices

409. On 17 June 2020, Health Technology Wales ("HTW") produced a 'rapid summary' report on the effectiveness of home monitoring using oximetry in people with Covid-19 symptoms. The report noted that recently published UK and international guidance recommended oximetry to help manage Covid-19, including in the home setting. It found that systematic reviews had identified that there was currently a paucity of evidence in relation to home oximetry, though there were four directly applicable ongoing studies. The report was provided to the CSAH, Rob Orford and shared with the CMO(W) office. A copy of the report is exhibited in **AGM3WGO01/157 - INQ000226160.**

410. In June 2020, the Welsh Government asked NWSSP to distribute additional pulse oximeters to general practices across Wales in support of advice issued in Welsh Health Circular WHC/2020/12, a copy of which is exhibited **AGM3WGO01/158 - INQ000048607** which recommended their use by GPs to aid clinical assessment. Subsequent to this distribution, the NHS National Clinical Lead for Primary Care arranged for additional devices to be distributed to all practices in Wales with instructions included for patients on how to use devices for self-monitoring to enable practices to provide devices to patients if they wanted to. The position in this Circular was however clear that the use of remote or home monitoring use of pulse oximetry machines was not being advocated by the Welsh Government and its use remotely was a matter for local decision making.

411. A pilot of Covid-19 virtual wards was however progressed by the NHS Medical Directors group, with support from the Welsh Government. These plans were discussed in October 2020 and noted the need for prioritising vulnerable groups, including those minority ethnic backgrounds. Virtual wards would include pulse oximeters used at home with support from local teams in the community. Proposals were drawn up and put forward by the All Wales Medical Directors group. Exhibits **AGM3WGO01/159 - INQ000227259** and **AGM3WGO01/160 - INQ000227260** refer.

412. A further rapid evidence summary was produced in June 2021 by Health Care and Research Wales in collaboration with the Wales Covid-19 Evidence Centre, as an update to the HTW summary from the year prior. The aim of this report again was to consider the effectiveness of home monitoring using pulse oximetry in Covid-19 patients. A copy of this report is exhibited in **AGM3WGO01/161 - INQ000421660**[73]**.** The report included reference to research indicating that inaccuracies had been reported in people with dark skin. It concluded, citing evidence from a number of reviews, that there remained questions about the safety and cost of home monitoring using oximeters and that it was not clear whether the changes in patient care would justify the cost of buying the equipment and monitoring the results. The Welsh Government's position as set out in the Welsh Health Circular exhibited above (AGM3WGO01/158 - INQ000048607) remained unchanged so the use of remote monitoring remained a matter for local discretion based on the needs of the health board area population.

NHS capacity, field hospitals and use of private sector in Wales

413. For this section of my statement, I have sought support from Samia Edmonds and Andrew Sallows. Samia Edmonds, through her role as chair of the Covid-19 Planning and Response Group, had responsibility, along with Andrew Sallows, for oversight of NHS capacity and demand. From early March 2020 they had been in regular contact with health boards to understand each health board area's respective position.

414. In order to address capacity issues, the NHS in Wales had three principal approaches:

[73] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227191]

I. Stepping down of non-essential (non-covid) services/ activity;

II. Maximising existing local NHS capacity and creating additional, extra surge capacity (e.g. field hospitals); and

III. Use of the private sector.

415. I will outline all three below to reflect on how they impacted assessment of NHS capacity and the role of NHS Wales in informing that assessment.

NHS capacity

416. Thanks to the hard work undertaken by Health and Social Services Group and NHS colleagues, our capacity plans allowed us to meet the demands as they occurred. During the early phases of the pandemic this was achieved because of the system actions and preparation that were put in place, as detailed further below in the section headed admission and discharge. These actions meant that we had beds free notably through the first wave and into the second wave. However, once NHS activity was reintroduced later in the pandemic there were local and national points when this was more difficult, particularly due to the uncertainty around variants of concern.

Number of inpatient and critical beds available and occupancy levels in the NHS in Wales as at or around 1 March 2020

417. The number of inpatient and critical beds available and occupancy levels in the NHS in Wales as at 1 March 2020 is not available. This data was first available to the Welsh Government from 23 March 2020. A copy of the daily sitrep reports for 30 March 2020 to 3 April 2020 is exhibited as **AGM3WGO01/163 – INQ000421661.** This data does not include community hospital or private hospital data which were not being recorded at this time. Available beds were beds for which there was ward space, linens, medical equipment, and consumables available for treating patients. This however was a constantly developing situation which is why daily data was collected. A summary of the all-Wales data on 30 March 2020 is provided in the table below which shows:

- Total critical care beds available 304 with 113 beds (37%) occupied.
- Total acute beds available 6918 with 3600 beds (53%) occupied.

- Total designated Covid-19 acute beds available 1316 beds with 465 (35%) occupied.

Bed capacity data on 30 March 2020

Table 1 Capacity and occupancy at census time			Occupied						
			Covid-19						
		Total	Suspected	Confirmed	Non Covid-19	Total occupied	Closed	Vacant	% occupancy
Invasive ventilated beds	Invasive ventilated beds in a critical care environment	220	9	55	43	107	1	112	49%
	Invasive ventilated beds in a hospital but outside of critical care environment	84	2	2	2	6	0	78	7%
	Temporary beds providing invasive ventilation outside of a hospital building	0	0	0	0	0	0	0	
	Total invasive ventilated beds	**304**	**11**	**57**	**45**	**113**	**1**	**190**	**37%**
Other (non-invasive ventilated) beds	Designated Covid-19 hospital beds providing CPAP	62	14	13		27	0	35	44%
	Designated Covid-19 hospital beds with non-invasive ventilation	94	16	29		45	0	49	48%
	Designated Covid-19 hospital beds - palliative	20	0	4		4	0	16	20%
	Designated Covid-19 hospital beds - other	1140	128	261		389	60	691	34%
	Total designated Covid-19 hospital beds	**1316**	**158**	**307**		**465**	**60**	**791**	**35%**
	Non designated Covid-19 hospital beds	5602	69	23	3043	3135	36	2431	56%
	Total hospital beds	**6918**	**227**	**330**	**3043**	**3600**	**96**	**3222**	**52%**
	Temporary beds providing hospital care outside of a hospital building	0	0	0	0	0	0	0	
	Total other (non-invasive ventilated) beds	**6918**	**227**	**330**	**3043**	**3600**	**96**	**3222**	**52%**
Mortuary	Spaces in hospital mortuary	1070				642		428	60%
	Spaces outside of a hospital mortuary	49				0		49	
	Total spaces	**1119**	**0**	**0**	**0**	**642**	**0**	**477**	**57%**

418. Available surge capacity data was added to the daily bed occupancy sitrep report from 4 April 2020 on and a copy of the sitrep report on that date is exhibited at **AGM3WGO01/164 – INQ000421646.** This report shows that at that time there was an additional surge capacity of 408 critical care beds, 90 of which could be available within 24 hours, 89 were available between 24 hours and 7 days and the remaining 229 beds were available after 7 days. Additionally, there was an additional surge capacity of 6386 acute care beds, 1595 of which could be available within 24 hours, 1241 available between 24 hours and 7 days and 3550 that could be made available after 7 days. This included 130 acute level beds in operation in community hospitals which were all filled and with no additional surge capacity. At this time, field and private hospitals were not being used and are therefore not included in the figures shown. As detailed later in this statement at paragraph 449, the data provided to the Welsh Government noted these were available beds however until November 2020 we did not have assurance from the NHS in Wales that all available beds could be staffed.

Bed capacity data on 4 April 2020

Table 1 Capacity and occupancy at census time			Occupied							Surge Capacity		
			Covid-19									
		Total	Suspected	Confirmed	Non Covid-19	Total occupied	Closed	Vacant	% occupancy	Additional capacity that can be made available within 24 hours	Additional capacity that can be made available between 24 hours and 7 days	Additional capacity that can be made available after 7 days
Invasive ventilated beds	Invasive ventilated beds in a critical care environment	250	15	94	46	155	0	95	62%	87	76	114
	Invasive ventilated beds in a hospital but outside of critical care environment	106	5	8	14	27	0	79	25%	3	13	115
	Temporary beds providing invasive ventilation outside of a hospital building	0	0	0	0	0	0	0		0	0	0
	Total invasive ventilated beds	**356**	**20**	**102**	**60**	**182**	**0**	**174**	**51%**	**90**	**89**	**229**
	Total designated Covid-19 hospital beds	1812	193	428		621	100	1091	34%	1044	554	410
	Non designated Covid-19 hospital beds	4974	110	133	2448	2691	70	2213	54%	551	687	630
	Total hospital beds	**6786**	**303**	**561**	**2448**	**3312**	**170**	**3304**	**49%**	**1595**	**1241**	**1040**
	Temporary beds providing hospital care outside of a hospital building	0	0	0	0	0	0	0		0	0	2510
	Total other (non-invasive ventilated) beds	**6786**	**303**	**561**	**2448**	**3312**	**170**	**3304**	**49%**	**1595**	**1241**	**3550**
Mortuary	Spaces in hospital mortuary	988				563		425	57%	0	0	0
	Spaces outside of a hospital mortuary	34				0		34		0	0	600
	Total spaces	**1022**	**0**	**0**	**0**	**563**	**0**	**459**	**55%**	**0**	**0**	**600**

Planning of NHS capacity required and reasonable worst case scenario

419. It was not clear at the very early stage what level of capacity was required but this was subsequently confirmed using the UK-wide methodology developed by Imperial College, London. The Imperial model on which NHS planning assumptions was based was an infectious disease model designed to predict the numbers of cases arising in different age groups over time and how this would change if the numbers of contacts in various settings (home, work, leisure) changed as a result of behavioural and social interventions (BSI). The model aimed to estimate the impact without intervention, and the impact with interventions, in order to guide policymakers as to which intervention to use and when. It did not aim to provide a "road map" for the progress of the epidemic in any particular part of the UK. The key points from the modelling were:

    a) New cases are expected to peak 11 weeks from start of epidemic without behavioural interventions.

    b) Without behavioural interventions demand for services is likely to peak around weeks 12-14.

420. There would be considerable variation by health board based on the local timing of the outbreak, size of the resident (and non resident) population, and proportion of vulnerable people (older, co-morbidities, social deprivation). Adjusting the model assumptions by simple scaling down gave lower demand – but still indicated that demand was set to exceed supply.

421. TAC advice on the 15 March 2020 9 (exhibited as **AGM3WGO01/164a – INQ000312895**) indicated if all three social interventions (i.e. self-isolation, household quarantining, shielding vulnerable groups and over 70s) were in place in Wales early in the epidemic there would be a peak need for 1,595 ICU units and 16,552 hospital beds. This meant if every single NHS Wales bed was available to Covid-19 patients there would be a deficit of -5,989 beds at peak and -1,447 ICU beds - if all current NHS capacity was available. The advice was the deficit was likely to be higher.

422. The UK modelling methodology developed by Imperial College London was utilised and version 2.3 of the modelling for NHS Wales projected a necessity for 900 critical care and an additional 10,000 system wide beds at the point of peak demand.

423. Modelling was produced by NHS England and NHS Improvement and was based on the following key assumptions:

a) Proportion of population who become infected: in RWC 80.5%

b) Proportion of infected people who would normally require hospitalisation: 4.4%

c) Proportion of hospitalised people who require critical care: 30.0%

d) Average length of stay for patients not requiring any critical care: 8.2 days

e) Average length of stay for patients who require any critical care: 15.6 days (of which 9.6 in critical care.

424. This analysis did not factor in any seasonal effect, any further potential measures to improve capacity, the effect of any non-pharmaceutical interventions, the impact of supply shortages on the provision of treatment, any staff shortages that may arise or triage by resource that may be implemented.

Building NHS capacity

425. The need to build capacity in NHS Wales was recognised early in the pandemic and the CMO(W) wrote to health bodies on the 13 February 2020 to highlight the need to increase capacity across the NHS estate to manage possible Covid-19 patients who require admission, and the need for isolation facilities and an appropriately trained workforce. A copy of this letter is exhibited in **AGM3WGO01/165- INQ000227377.**

426. The CMO(W) in his letter requested a summary from each health board on their preparedness to be submitted by the end of the month. A summary of the returns received was prepared on the 5 March 2020 and is exhibited in **AGM3WGO01/166 - INQ000226922.**

427. Welsh Government also took steps to support the increase of capacity across the NHS by working with NHS Wales. On the 20 March 2020 the Minister for Health and Social

Services was asked to agree to the early handover to Aneurin Bevan University Health Board of parts of the new Grange University Hospital. This was anticipated to provide up to 350 additional beds to support lower acuity patients by the end of April 2020. A copy of the Ministerial Advice is exhibited in **AGM3WGO01/167 - INQ000338220**.

428. On 4 April 2020 I wrote to the local health boards to discuss their capacity plans which had been submitted to outline the levels of additional critical care and acute beds that they were targeting to bring online in the coming weeks and months. A copy of the letter is exhibited in **AGM3WGO01/168 - INQ000227011.** As outlined in the letter, the target we were trying to achieve for Wales was to accommodate the Reasonable Worse Case Scenario which predicted the total critical care capacity and additional acute capacity as outlined in the table below. The 40% RWC (Reasonable Worst Case) figure referred to in the letter and in the table below refers to SAGE modelling based on a 40% compliance with control measures in Wales with the proportion of infected people who would normally require hospitalisation being 4.4% and the proportion of hospitalised people who require critical care being 30.0%. The 'Critical Care' column in the table below refers to the total capacity targeted (including existing beds and additional beds) whereas the 'Additional Acute' column refers only to the additional number of beds targeted.

Table 7: NHS Covid-19 Capacity

Health Board	COVID CAPACITY	
	RWC (40%) Critical Care	RWC (40%) Additional Acute
All Wales Requirement	**900**	**10,000**
Aneurin Bevan University Health Board	170	1,884
Betsi Cadwaladr University Health Board	200	2,220
Cardiff and Vale University Health Board	143	1,592
Cwm Taf Morgannwg University Health Board	128	1,419
Hywel Dda University Health Board	110	1,225
Powys Teaching Health Board		419
Swansea Bay University Health Board	112	1,242

429. Local health boards were asked to deliver a proportional percentage increase in capacity. This was not a blanket percentage increase across all hospitals or local health boards, but varied depending on the local provision of services and their ability to respond. For example, Powys does not have any acute hospitals and so no provision for critical care, so neighbouring local health boards were asked to deliver a proportion of the capacity for Powys. This was based on the likely flow of patients, derived from historic patient resident activity levels.

430. The local health boards were asked to report on progress against these targets. The information obtained was summarised for the Minister on the 8 April 2020 as set out in the briefing exhibited in **AGM3WGO01/169 - INQ000352986,** which noted growing confidence that sufficient bed capacity would be available over the next 3-4 weeks (which it proved to be) and included the following table:

Table 8: Expected NHS Covid Capacity

Health Board	Venue (type)	Type	Additional general acute beds
Cardiff & Vale	Principality	Field	+2000
	Spire	Private	+60
Aneurin Bevan	Grange	New NHS Hospital	+350
	St Joseph's	Private	+36
Betsi Cadwaladr	Spire, Wrexham	Private	+27
	Venue Cymru	Field	+350
	Deeside leisure centre	Field	+246
	Bangor University	Field	+250
Cwm Taf Morgannwg	Vale Hospital , Hensol	Private	+27
	WRU resource centre	Field	+270
	Ty Trevithick (Abercynon)	Field	+150
	Additional beds made available in care home and community wards for step-down and non-acute care.		+462
Hywel Dda	Parc Y Scarlets	Field	+368
	Bluestone	Filed	+128
	Selwyn Samuel centre, Llanelli	Field	+143
	Werndale hospital, Carmarthen	Private	+30
Powys	The health board was actively pursuing a number of options, with the support of military liaison officers, and an announcement is anticipated soon.		
Swansea Bay	Llandarcy Academy of Sport	Field	+360
	Bay studios	Field	+1080
	Sancta Maria Hospital	Private	+29

431. I wrote to local health boards again on 24 April 2020 and confirmed my agreement with the approaches to continuing, reducing or in some cases halting work on additional capacity which the individual local health boards had communicated. I

confirmed that capacity would not currently be commissioned and operationalised unless needed, based on a local area assessment of need across health and social care. I also indicated that, given the uncertainties in future demand, operational planning was best undertaken in short cycles of 2-3 weeks, alongside the development of escalation plans which enabled local health boards to manage capacity in a flexible and responsive way. A copy of this letter is exhibited in **AGM3WGO01/170 - INQ000395661.**

432. Data reflecting the total additional bed capacity requirements against the targets set in my letter of 4 April as previously exhibited at AGM3WGO01/168- INQ000227011 is not available due to the way data was recorded and the date that we began to receive the data from Digital Health and Care Wales (DHCW) who would be better placed to provide that information.

Details of the inpatient and critical care bed capacity and occupancy levels in Wales during the relevant period

433. From 23 April 2020 the Welsh Government published on its website a weekly output of management information related to NHS activity and capacity. The weekly output became monthly from April 2022 onwards. This included data on critical care beds in use in Wales. The basic data indicates that there were no issues with NHS hospital capacity in Wales during the pandemic period, however the significance of tracking this, linked assessment of the five 'harms' and decision around restrictions and lockdowns, as well as linking data to the modelling was extremely challenging.

434. Bed capacity data was submitted by health boards and Velindre NHS Trust on data pro formas to Digital Health and Care Wales. They were then responsible for compiling and validating the data before sending daily SitRep report spreadsheets to the Welsh Government which contained the amalgamation of all the returns each day from 23 March 2020. In terms of what categories of data must be collected for Sit Reps this was determined in discussion with the Chief Scientific Advisor for Health, Chief Statistician and NHS in Wales.

435. Prior to the pandemic detailed statistics were published via the StatsWales website by local health board, hospital site and speciality. The data includes all beds in NHS hospitals in Wales. Data has been published since 1989-90 so users can see a long

term trend on bed use. data was collated by the NHS Wales Informatics Service (NWIS) and presented at an all Wales and local health board level for average daily available beds, average daily occupied beds and occupancy rates. The data covered all beds in NHS hospitals in Wales. Each bed and patient attendance was classified by specialty. High Dependency Care and Intensive Care was excluded from the data. Data for these were included under the appropriate specialty but were not included in totals.

436. The data collection however used administrative data held by hospital systems. This means that the data have been collected for administrative purposes and not statistical purposes. Data provided to NWIS was aggregated, which limited the validation that could be carried out by NWIS. The StatsWales information was intended for a more informed audience and due to the devolved governments and differing policy, there was little scope for UK comparisons.

437. In response to the pandemic, daily information on NHS beds was collected specifically to support transparency and understanding of NHS activity and capacity. Figures show the number of invasive ventilated beds and general and acute beds by use, hospital type, local health board and date.

438. The daily sitrep spreadsheet reports presented data on an all-Wales level as well as allowing a breakdown by each health board or individual hospital on any given day. Bed capacity data included the number of invasive ventilated beds, designated Covid-19 and non-Covid-19 beds, temporary beds outside of a hospital setting and their respective occupancy rates. This process took a few days to become properly established and so the initial dates to 29 March contained incomplete data. Although we can provide details of data provided to the Welsh Government on any given day, as data owners, Digital Health and Care Wales would be best placed to answer questions if a deeper analysis is required than can be extracted from the daily updates such as regional breakdowns of data over longer periods of time.

439. The number of additional beds that may need to be made operational was managed through local assessment by each local health board. A reserve surge capacity of critical care and acute beds were available to be mobilised within 24 hours, within 24 hours to 7 days or available in over 7 days. To assist health boards in respect of this

local assessment data on community infection rates was made available via regular updates from via Public Health Wales. In additional guidance was provided in the form of the quarterly NHS Wales Operating Frameworks (as outlined and exhibited in paragraph 202 above) which took into account the modelling and RWCS coming from the Technical Advisory Cell and Technical Advisory Group to enable NHS Wales to plan in the short term with a particular focus on NHS capacity.

440. Both the capacity and the occupancy of inpatient and critical care beds varied day to day. The availability of that capacity likewise fluctuated daily and would depend on the occupancy.

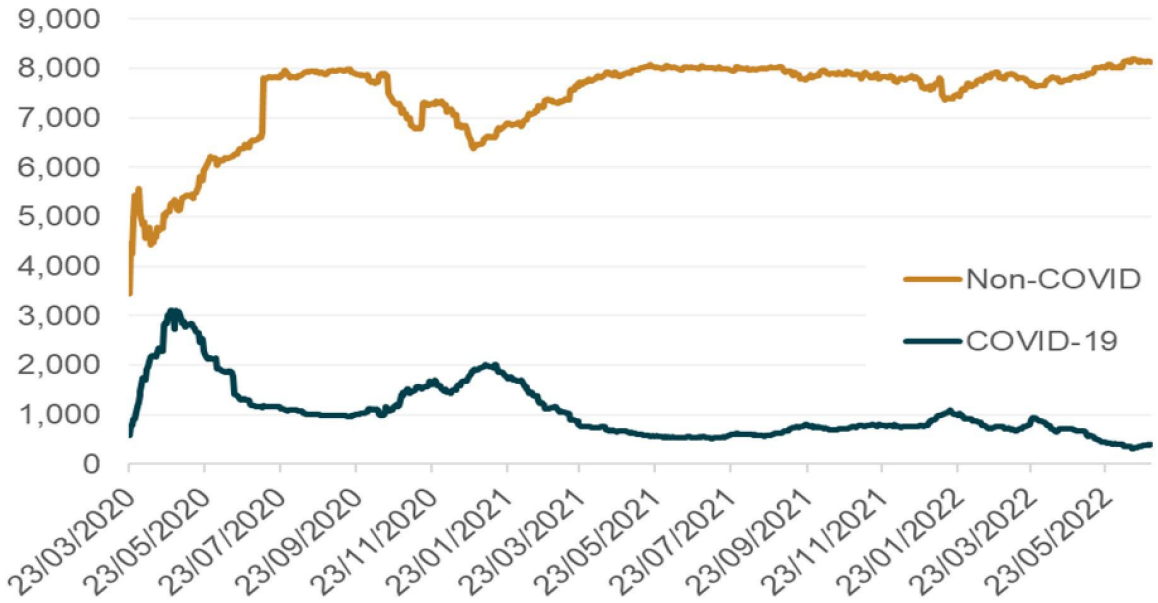
441. The Welsh Government retain the spreadsheets described above should the Inquiry request them. Given the volume of the documentation I have not set out the daily fluctuations in this statement however, with assistance from the Welsh Government's statistician team I have set out the aggregated data in the graphs below to assist the Inquiry.

Bed availability (capacity)

442. Figure 1 below depicts the daily ward level (general and acute) beds available by Covid-19 designation, Wales, March 2020 to June 2022. It illustrates that beds designated for Covid-19 patients reached over 3,000 in April and May 2020, with a later peak reaching 2,000 in January 2021. For beds not designated for Covid-19 patients, the sharp increases reflect the addition of field and community hospitals (April 2020), mental health units (July 2020) and the Grange University Hospital (November 2020) in the data collection. A reduction in beds designated for Covid-19 patients in early 2021 corresponded to an increase in non-COVID beds and figures for both series were relatively stable thereafter.

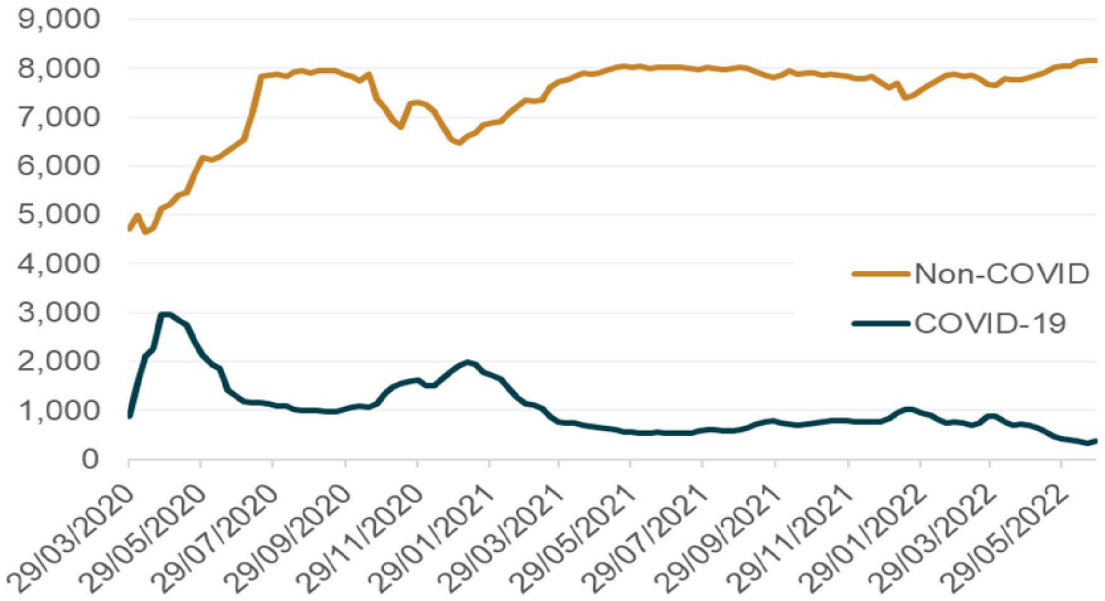
443. Until 18 October 2020 a subset of beds ringfenced for specialist purposes (for example maternity, burns and plastics) were reported as non-Covid-19. From 19 October 2020 those beds were not captured in this collection, causing a reduction of 400-800 in the reported number of non-Covid beds compared with the series prior to this point. The true number of general and acute beds available in Wales was therefore 400-800 more than the total of designated Covid and non-Covid beds from 19 October 2020.

Figure 1- Daily ward level (general and acute) beds available by COVID-19 designation, Wales, March 2020 to June 2022



444. Figure 2 below depicts the weekly average ward level (general and acute) beds available by COVID-19 designation, in Wales, from March 2020 to June 2022.

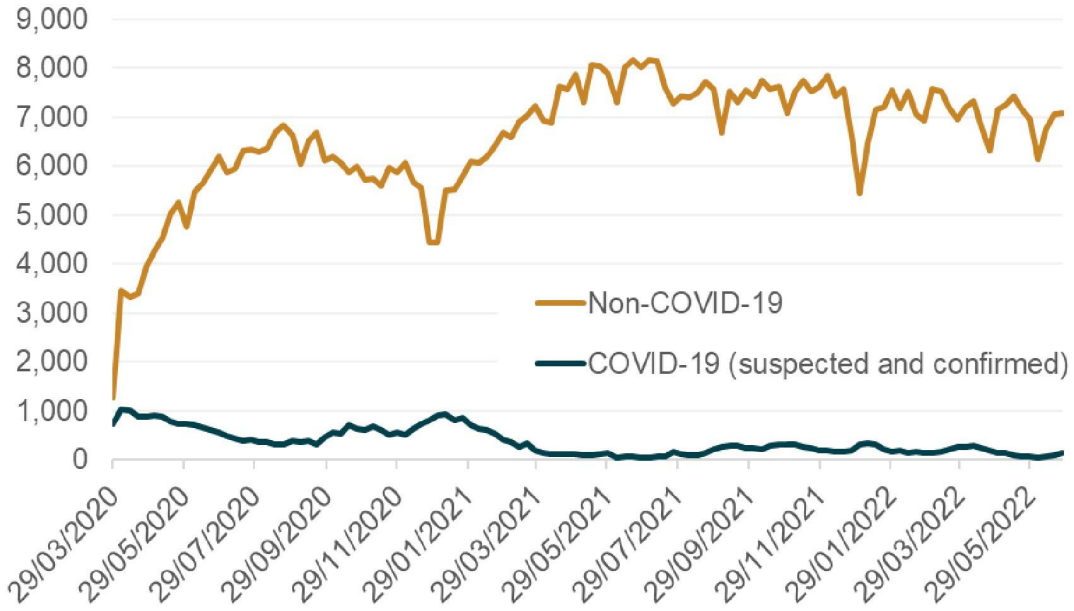
Figure 2- Weekly average ward level (general and acute) beds available by COVID-19 designation, Wales, March 2020 to June 2022



Hospital admissions (occupancy)

445. Figure 3 below illustrates the weekly new hospital admissions for Covid-19 (suspected and confirmed) and non-Covid-19 conditions, in Wales, from March 2020 to June 2022. The diagram highlights that weekly hospital admissions for Covid-19 (suspected and confirmed) peaked in early April 2020 at over 1,000, before falling to around 300 in August 2020. Further waves saw weekly admissions climb over 700 in October 2020 and over 900 in January 2021. Admissions for non-Covid-19 conditions were consistently far higher, typically ranging from 5,000 to 8,000 per week. For 23 March 2020 to 31 March 2020 admissions, the data was available for suspected and confirmed Covid-19 patients separately, and from 01 April 2020 admissions data were collected for confirmed and suspected Covid-19 patients combined.

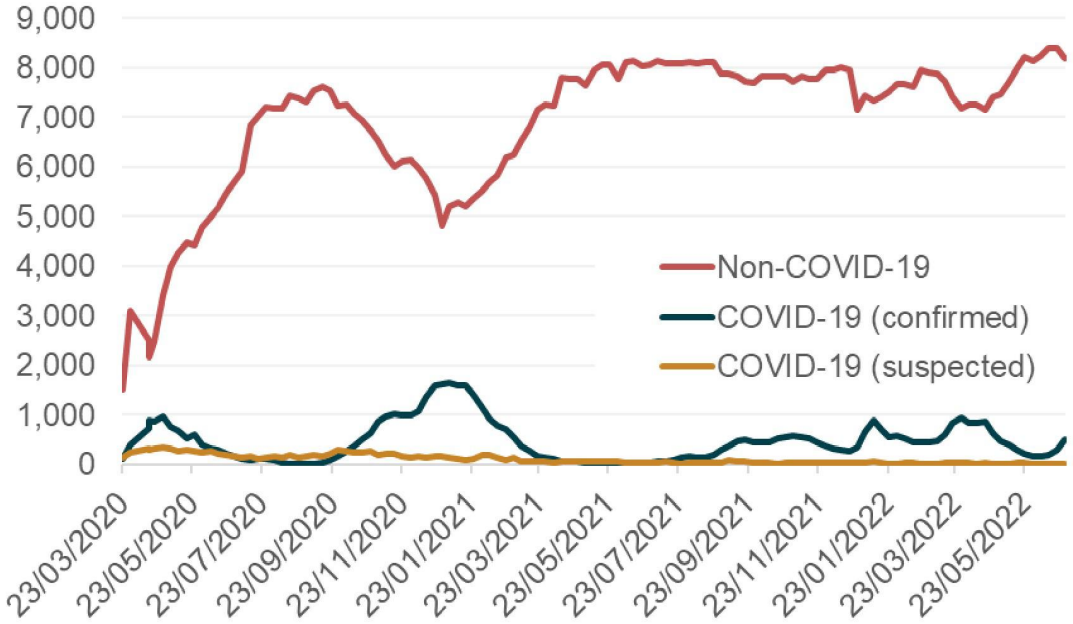
Figure 3 - Weekly hospital admissions for COVID-19 (suspected and confirmed) and non-COVID-19 conditions, Wales, from March 2020 to June 2022



446. Figure 4 below illustrates the weekly number of patients in hospital with confirmed Covid-19, suspected Covid-19 and non-Covid-19, in Wales, from March 2020 to June 2022. The data highlights that those patients in hospital with confirmed Covid-19 reached 967 in April 2020 before falling to single figures in August 2020. The figure peaked at over 1,600 in January 2021. Subsequent waves also saw significant numbers of hospital patients with confirmed Covid-19 in the first few months of 2022, though data was not available in terms of how many were actively being treated for

Covid-19 and how many were treated primarily for other conditions. Admissions data for the same period indicate that waves after the summer of 2021 were less significant (in terms of the number of patients) than earlier waves. Data for patients in hospital with suspected Covid-19 peaked at around 340 in April 2020 and subsequent waves saw lower peaks. Patients in hospital with non-Covid-19 conditions were consistently significantly higher than for Covid-19 patients, typically between 5,000 and 8,000.

Figure 4 - Weekly patients in hospital with confirmed COVID-19, suspected COVID-19 and non-COVID-19, Wales, March 2020 to June 2022



Critical care bed availability (capacity)

447. Figure 5 below illustrates the daily invasive ventilated (critical care) beds available, in Wales, from April 2020 to June 2022. Adult critical care beds are specifically for patients requiring intensive care or high-dependency care. These beds are available for critical care patients (levels 2 and 3) except for paediatrics. During the pandemic the daily SitRep information had a breakdown of the number of critical care beds on a daily basis. It included a breakdown of those in a critical care environment and those outside, i.e. those that were classes as 'surge' beds, however, it did not break down by level 2 or 3 beds. The definition for critical care beds was “providing or

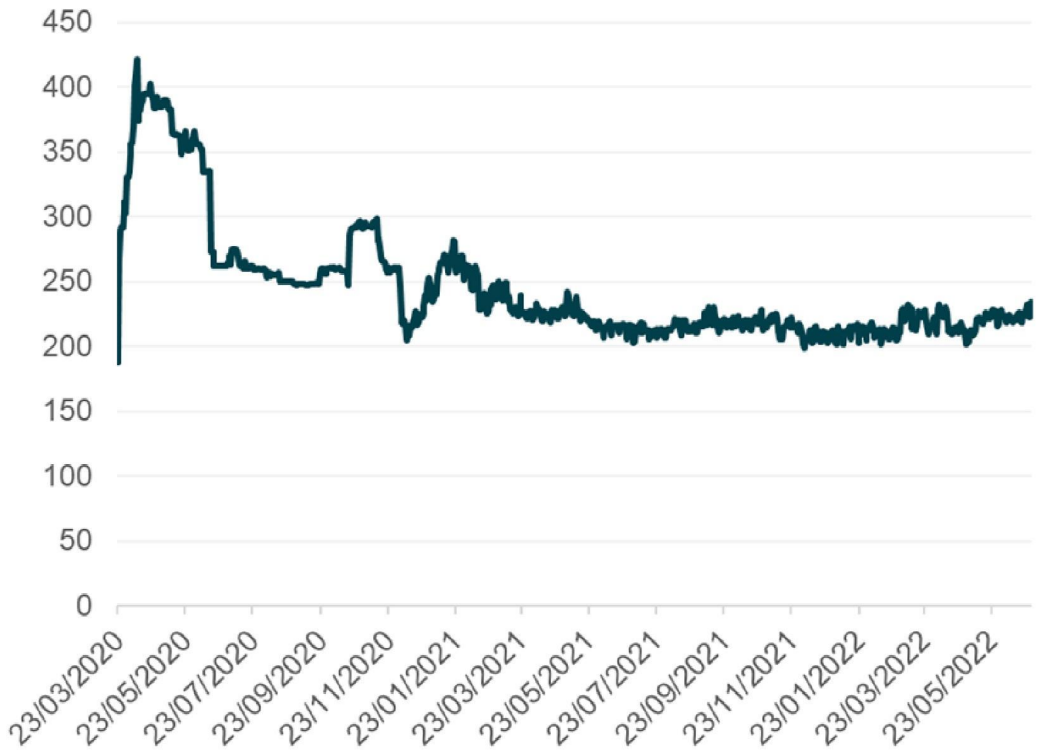
capable of providing level 2 / 3 critical care", but data on those sub-categories were not collected.

448. As set out in Figure 5, the daily available invasive ventilated (critical care) beds peaked at over 400 in April 2020. The raw data contained in the daily updates showed that the peak was 421 on 9 April 2020. Figure 5 also highlights that the numbers fell back and stabilised between 200 and 250 from early 2021. In terms of why critical care capacity reduced after April 2020 was because the demands were better understood after the initial wave, so some of the earlier capacity could be released.

449. The available beds set out in figures 5 and 6 were those available at the time the data was collected – i.e. immediately. Until 13 November 2020 (4 December 2020 for some health boards) this data focussed on whether the beds existed, and after then they should only have been reported if they could be staffed. Data on additional 'surge' capacity, for beds that could be available within 24 hours, 7 days or after 7 days, was collected separately.

450. I understand that the data for critical care beds is not available according to whether they were designated for Covid-19 or non-Covid-19 patients. Neither is the data available for high dependency or intensive care specifically – figures are therefore provided for total "critical care" beds.

Figure 5 - Daily invasive ventilated (critical care) beds available, Wales, April 2020 to June 2022



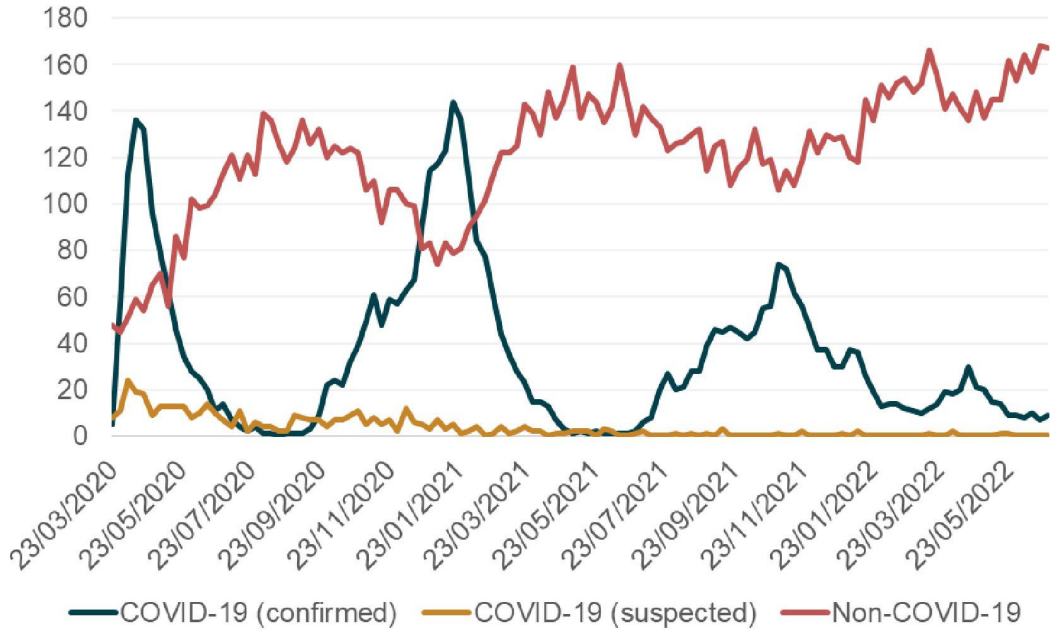
451. Figure 6 below illustrates the weekly average invasive ventilated (critical care) beds available, in Wales, from April 2020 to June 2022. It highlights the same trends as described above in terms of daily invasive ventilated beds. Again, up until 13 November all critical care beds should have been reported regardless of whether they could be staffed.

Figure 6- Weekly average invasive ventilated (critical care) beds available, Wales, April 2020 to June 2022

Critical care admissions (occupancy)

452. Figure 7 below illustrates there were three significant waves of patients occupying critical care beds in Wales, with peaks in April 2020, January 2021 and November 2021. Patients with suspected Covid-19 consistently accounted for a small minority of those in critical care. There were always more non-Covid than Covid-related patients in critical care apart from the first two peaks in Covid patients. The data are the daily snapshots at weekly intervals, not total weekly figures and the data are for patients in critical care beds, which includes those in high dependency and intensive care.

Figure 7 - Weekly patients in invasive ventilated beds (critical care) with confirmed COVID-19, suspected COVID-19 and non-COVID-19 conditions, Wales, April 2020 to June 2022



453. The data illustrated in Figure 7 above are also termed 'invasive ventilated beds'. Unfortunately, the data held by Welsh Government cannot be disaggregated according to whether they were occupied by invasively ventilated patients or not.

454. Neither field hospitals nor private healthcare contributed critical care or acute care to Covid-19 patients. As set out below, Field hospitals were used on the step down pathway and private hospitals were used as "green sites" to treat non Covid-19 patients. Private hospitals may have provided critical or acute care to non-Covid-19 patients and, as such, they will have been included in the daily figures described above. These figures fluctuated daily and so it is not possible to give the Inquiry a single figure of critical or acute care capacity in private hospitals and DHCW would be better placed to provide this information as data owners.

455. The data has been reviewed to identify incidents in which there were substantial issues as to bed capacity. At no point were bed capacity limits breached in Wales. The highest overall occupancy rate was 94% of bed occupancy which was reached in June 2022. This includes critical care, acute level, field hospitals, private hospitals and community hospital beds but additional surge capacity remained available if required. A

breakdown of the bed capacity data taken from the daily SitRep reports at peak occupancy levels during each wave is provided below. In terms of whether critical care capacity, or general bed capacity, was reached or exceeded in any local health board or individual hospital DHCW will be best placed to confirm this information.

456. During the first wave of the pandemic, the highest bed occupancy rate across all bed types was reached on 27 May 2020 with 5,691 (65%) beds occupied against a total of 8,764 beds available. The number of available beds is calculated based on the number of beds minus any which have been closed off. Closed beds are the number of beds closed for any non-staffing reason (e.g. due to being damaged or for decontamination). On this date, there were 354 critical care beds available with 133 (38%) occupied and 7,006 acute care beds available (including field hospitals and private hospitals) with 4,634 (66%) occupied. There were also 1,404 Community beds available with 924 (66%) occupied. Community beds are beds that are within a community hospital setting. A community hospital is defined as 'In-patient care provided does not require the highly technical specialist support of an acute hospital. In-patient care provided under the supervision of GP's, specialist doctors or nurses, may include a minor injury service and elderly mentally ill beds. Where care is provided by consultants this is usually for elderly patients. Other services such as out-patient clinics, diagnostic and therapy services and day care may also be provided. Would not receive major acute emergency admissions. Would not be expected to undertake in-patient general surgery requiring general anaesthesia'. Additional surge capacity was also available with 740 beds available in less than 24 hours, 490 beds available between 24 hours and 7 days and 5,200 beds available after 7 days. This information is set out in the table below:

27 May 2020								
Bed Type	**Operational beds**	**Closed**	**Beds available**	**Occupied**	**Vacant**	**Additional surge within 24 hours**	**Additional surge 24 hours to 7 days**	**Additional surge after 7 days**
Critical Care	370	16	354	133 (38%)	221	46	113	177
Acute Care	7543	537	7006	4634 (66%)	2372	650	324	4858
Community	1462	58	1404	924 (66%)	480	44	53	165
Mental Health	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total Beds	**9375**	**611**	**8764**	**5691 (65%)**	**3073**	**740**	**490**	**5200**

457. During the second wave of the pandemic, the highest bed occupancy rate of 86% across all bed types was reached on 18, 21 and 29 September 2020. Figures have been provided in the table below for 29 September 2020 as this date also had the highest occupancy rate for critical care beds out of the three dates (62%). There were 7,905 (86%) beds occupied against a total of 9,235 beds available. There were 260 critical care beds available with 162 (62%) occupied; 6,158 acute care beds available (including field hospitals and private hospitals) with 5,356 (87%) occupied; 1,407 community beds were available with 1,236 (88%) occupied and 1,410 mental health beds available with 1,151 (82%) occupied. Additional surge capacity was also available with 624 beds available in less than 24 hours, 1,055 beds available between 24 hours and 7 days and 2,490 beds available after 7 days.

29 September 2020								
Bed Type	**Operational beds**	**Closed**	**Beds available**	**Occupied**	**Vacant**	**Additional surge within 24 hours**	**Additional surge 24 hours to 7 days**	**Additional surge after 7 days**
Critical Care	262	2	260	162 (62%)	98	29	94	98
Acute Care	6371	213	6158	5356 (87%)	802	542	908	2227
Community	1436	29	1407	1236 (88%)	171	45	53	165
Mental Health	1415	5	1410	1151 (82%)	259	8	0	0
Total Beds	**9484**	**249**	**9235**	**7905 (86%)**	**1330**	**624**	**1055**	**2490**

458. The highest bed occupancy rate of 94% across all bed types during the relevant period was reached during the last 2 weeks of June 2022. Figures have been provided in the table below for 30 June 2022 as this date also had the highest occupancy rate for critical care beds during this period with 83% occupied. There were 8,977 (94%) beds occupied against a total of 9,517 beds available. There were 228 critical care beds available with 190 (83%) occupied; 6,550 acute care beds available (including field hospitals and private hospitals) with 6,219 (95%) occupied; 1,390 community beds were available with 1,348 (97%) occupied and 1,349 mental health beds available with 1,220 (90%) occupied. Additional surge capacity was not being recorded by this time.

30 June 2022								
Bed Type	**Staffed beds**	**Closed**	**Beds available**	**Occupied**	**Vacant**	**Additional surge within 24 hours**	**Additional surge 24 hours to 7 days**	**Additional surge after 7 days**
Critical Care	230	2	228	190 (83%)	38	n/a	n/a	n/a
Acute Care	6603	53	6550	6219 (95%)	331	n/a	n/a	n/a
Community	1415	25	1390	1348 (97%)	42	n/a	n/a	n/a
Mental Health	1364	15	1349	1220 (90%)	129	n/a	n/a	n/a
Total Beds	**9612**	**95**	**9517**	**8977 (94%)**	**540**	n/a	n/a	n/a

Guidance to health boards on stepping down of services/non-covid activity and discharge

459. The week commencing the 9 March 2020 discussions with the NHS Chief Executives took place as it was recognised that departments were losing staff to sickness already and there were concerns about more staff shortages and there were significant concerns about the projected increases in Covid case numbers. Discussions came to a head on the 13 March 2020 and I met with the NHS Chief Executives that day to discuss capacity and the step down of services. The Minister for Health and Social Services agreed to make a statement at 4pm that day about health bodies pausing some routine activities in order to support organisations in preparation for the expected increase in Covid-19 demand. A copy of this statement is provided in exhibit **AGM3WGO01/171-INQ000320755.** The statement set out a framework of 10 actions which health bodies could locally assess and action as required:

1. Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised.

2. Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery).

3. Prioritise use of non-emergency patient transport services to focus on hospital discharge and ambulance emergency response.

4. Expedite discharge of vulnerable patients from acute and community hospitals.

5. Relax targets and monitoring arrangements across the health and care system.

6. Minimise regulation requirements for health and care settings.

7. Fast track placements to care homes by suspending the current protocol which gives the right to a choice of home.

8. Permission to cancel internal and professional events, including study eave, to free up staff for preparations.

9. Relaxation of contract and monitoring arrangements for GPs and primary care practitioners.

10. Suspend NHS emergency service and health volunteer support to mass gatherings and events.

460. In the early stages of the pandemic a stakeholder workstream, bringing together health and social care representatives, began preparing hospital discharge guidance for the sectors. This group produced the Hospital Discharge Service Requirements guidance. A copy of this guidance is exhibited in **AGM3WGO01/172 - INQ000227334.** The guidance states that health, social care and third and independent sectors were to follow its practices from 6 April 2020. While the guidance predominantly focused on responding to some of the discharge challenges presented by Covid-19, it did build on existing practical advice for working towards a 'home first' approach to discharge – strengthening practices like Discharge to Recover then Assess which aims to get patients on an appropriate pathway to minimise their stay and get them either back to their usual place of residence or their next stage of care at the earliest opportunity when safe and reasonable to do so. The requirements guidance did provide links to information supporting the treatment and discharge of patients with covid, but it also covered guidance more broadly for patients who did not have Covid-19, but might have had their discharge affected by Covid-19 (such as where a person is well enough to return to their home or care home but support services had been impacted by Covid-19 i.e. reducing staff numbers to provide safe service).

461. After this initial period in March and April subsequent guidance on pausing activity was issued via the Essential Services Framework and via the Quarterly Operating frameworks, as exhibited above in paragraph 93 of this statement.

General Practice appointment availability during the pandemic

462. The Welsh Government Health and Social Services Group did not collect data on the number of general practitioner ("GP") appointments for the pandemic period, or the level of utilisation. The NHS Covid-19 Datahub however did collect this information but it is not held by the Welsh Government. The Datahub went live on the 9 April 2020 and was run by NHS Wales Informatics Service (now referred to as Digital Health Care Wales ("DHCW")). This was an NHS Covid-19 database stored in the National Data Warehouse which include data flows to support the management of Covid-19. A summary of the data collected by the Datahub is set out in exhibit **AGM3WGO01/173 - INQ000226997.**

463. DHCW collected, via the Covid-19 Datahub, a count of the number of contacts in GP practices. These were not standardised or delineated into categories, so could not be reliably used to measure appointment activity.

464. Health and Social Services Group officials have since worked with GP practices to collect this information, and reporting of it began in December 2022, for months starting October 2022.

465. A range of relaxations to the General Medical Service ("GMS") contract and reporting requirements were put in place to reduce pressure and free up capacity for essential patient care. Exhibit **AGM3WGO01/174 - INQ000227418** dated 13 March 2020 refers. These included but were not limited to:

    a. Relaxation or suspension of elements of the GMS Access Standards from March 2020. Part of the Quality Assurance and Improvement Framework introduced in 2019, these were standards relating to patient access to GPs, such as the requirement that '25% of all pre-bookable appointments are bookable through a digital solution', which was relaxed on the basis that it was contrary to Covid-19 advice.

b. Rapid rollout of video consultation options and rollout of 'Attend Anywhere' across primary and secondary care to support remote consultation. Attend Anywhere is the digital product that delivers the National Video Consultation Service (NVCS). It allowed Welsh citizens to continue to access medical advice and assistance in a safe environment, reducing the risk for both patients and health and care professionals. The accelerated national roll-out to NHS Wales and primary care contractors commenced in April 2020 and by October 2021, over 250,000 remote video consultations had been delivered to patients in Wales.

c. Temporary changes and/or suspension to some GMS Enhanced Services with remote delivery where clinically appropriate.

d. Extension to reporting requirements (March 2020) to reduce system pressure.

e. Extension to deadline for completion of Quality Improvement projects to free up capacity for direct patient care.

f. Elements of cluster working requirements suspended. A 'cluster' refers to all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. GP practices within a cluster could collaborate with each other and take decisions to make better use of available funding, workforce and other resources. Throughout Covid-19, GP practices were able to collaborate and work at a primary care cluster level to ensure the most vulnerable patients in need continued to receive high quality care. Suspended requirements included, for example, the requirement for the GP Cluster Network to meet five times during the year.

466. The Health and Social Services Group also worked to put in place additional service provision with new Directed Enhanced Services for Easter/Bank Holiday and Christmas and New Year 2020 provision of GMS (extended opening hours)[74].

467. As a result of the contract relaxations, which saw changes or suspension of enhanced services, funding previously earmarked for the provision of these services was

[74] Primary Medical Services Easter weekend and bank holiday provision of essential general medical services during the COVID 19 pandemic) (directed enhanced service) Directions 2020.

available to be repurposed. In addition to the funding released through the contract relaxations noted above, the Health and Social Services Group also introduced a new Additional Capacity Fund in December 2021 in the sum of £2 million to support winter pressures and increase staffing capacity in GMS. This was increased to £4 million in April 2022, running recurrently for three years. The funds available for 2021-22 were allocated to local health boards to enable the reimbursement of 100% of the total cost of either additional posts upon appointment or additional hours worked by existing post holders. Some posts and hours continuing after April 2022 were eligible for 50% match funding under the 2022-23 scheme. The fund is managed by local health boards with support from NWSSP who undertake validation of applications for the fund, and the Welsh Government did not undertake any direct monitoring or assessment. An evaluation of the Fund is intended following 2024/25.

468. The number of referrals made by GPs to secondary care is collated by Stats Wales and stored on an interactive database. A table of the referrals by local health board (area of provider) and month, sourced from the online interactive database, is reproduced below.

Table 9: Referrals by GPs to Secondary care

TABLE: Referrals by local health board (area of provider) and month; last updated 18/05/2023

	All Wales LHB (Provider)	Betsi Cadwaladr University Local Health Board	Powys Teaching Local Health Board	Hywel Dda University Local Health Board (1)	Swansea Bay University Health Board (2)	Cwm Taf Morgannwg University Health Board (2)	Aneurin Bevan University Local Health Board	Cardiff & Vale University Local Health Board
Jan-20	71698	14484	1615	7228	11457	8975	15874	12065
Feb-20	67001	13762	1398	6904	10733	8185	14742	11277
Mar-20	51116	10200	1095	5156	8006	6044	11874	8741
Apr-20	21420	3725	436	2314	3064	2887	5575	3419
May-20	29282	5363	534	3131	4225	3747	7483	4799
Jun-20	42965	8033	754	4615	6585	5501	10423	7054
Jul-2020 (3)	52468	9645	945	5555	8368	6659	12661	8635
Aug-2020 (1)	48546	8827	924	5086	8162	6142	11317	8088
Sep-20	56603	10731	1040	5927	9758	6984	12875	9288
Oct-20	56782	10698	1076	5993	9321	6955	13453	9286
Nov-20	55315	10909	964	5680	8743	7175	12594	9250
Dec-20	49705	10404	903	5011	7393	6018	11659	8317
Jan-21	47455	9299	880	4461	7653	5871	11195	8096
Feb-2021 (4)	52995	10215	1045	5044	9240	6739	12088	8624
Mar-21	69116	12773	1372	6829	11796	8565	16301	11480
Apr-21	64460	11822	1285	6097	10931	8276	15331	10718
May-21	64376	12211	1289	6445	10807	8341	14919	10364
Jun-21	70768	13055	1495	7099	11913	9040	16629	11537
Jul-21	68870	12824	1314	7086	11709	8589	15946	11402
Aug-21	61440	11491	1269	6141	10429	7709	14047	10354
Sep-21	67293	13050	1335	6712	11214	8391	15552	11039
Oct-21	62509	12174	1239	6315	10238	7753	14570	10220
Nov-21	67699	13750	1360	6927	10973	8460	15487	10742
Dec-21	56364	10920	1131	5855	9146	6816	13171	9325
Jan-22	61517	11434	1264	6174	9961	7866	14565	10253
Feb-22	65409	12725	1320	6569	10549	8335	15012	10899
Mar-22	74038	14870	1514	7569	12195	9067	16567	12256
Apr-22	62311	12863	1095	6333	9472	8237	14008	10303
May-22	75509	16184	1318	7588	11633	10177	16596	12013
Jun-22	69450	15413	1177	6809	10737	9137	15343	10834
Jul-22	71100	15389	1217	6981	10855	9394	15719	11545
Aug-22	74744	17513	1450	7011	11295	10064	15901	11510
Sep-22	74749	17421	1387	7012	10755	10776	15978	11420
Oct-22	75774	17106	1422	7167	11574	11121	15820	11564
Nov-22	77217	17880	1503	7414	11220	11379	16160	11661
Dec-22	57857	12901	1198	5304	8317	8566	12467	9104
Jan-23	73727	16513	1261	6882	11045	11068	15695	11263
Feb-23	73696	16857	1413	6999	10942	11363	15292	10830
Mar-23	84532	19250	1623	8599	12538	12346	17142	13034

	Footnotes
1	Hywel Dda did not submit any data for mental health treatment codes in from August 2020 due to the Mental Health Migration project, in the months after the pandemic this accounted for between 90 to 180 referrals, but prior to the pandemic this would have accounted for around 240 referrals a month.
2	From 1st April 2019 health service provision for residents of Bridgend local authority moved from Abertawe Bro Morgannwg to Cwm Taf. The health board names have changed with Cwm Taf University Health Board becoming Cwm Taf Morgannwg University Health Board and Abertawe Bro Morgannwg University Health
3	In response to the current COVID-19 pandemic, Cwm Taf Morgannwg have set up a new service code to capture antibody testing & research. This has resulted in a rise in the number of referrals for infectious diseases in July 2020.
4	This data has been revised to include a resubmission of mental health treatment data by Hywel Dda following their move to a new mental health data system. The resubmitted data covers all months from August 2020 onwards, for which data was previously not available.

Emergency services capacity during the pandemic

469. The Welsh Government receives daily updates from the ambulance commissioning team on 999 call volumes, and on available emergency ambulance capacity by region. The raw data on this is not held the Welsh Government but is held by the National Data Warehouse operated by Digital Health Care Wales, therefore I am unable to provide the number of emergency ambulances available.

470. During the pandemic period a daily situation report was also developed and distributed by the National Collaborative Commissioning Unit which featured details of 999 call activity, bed capacity, availability of equipment etc. This information was also included in the NHS Covid-19 Datahub.

471. In February and March 2020, we did not know what to expect in terms of the demands on emergency ambulance response. There was no increase in the number of ambulance vehicles available but the Welsh Government collaborated with public service partners to facilitate emergency ambulance driving training for fire and rescue services officers. Available emergency ambulance response capacity increased significantly during the pandemic period due to the availability of fire and rescue services drivers, availability of additional military drivers and an increase in staff capacity following investment by Emergency Ambulance Services Committee and the Welsh Government. Available capacity was also restricted at times during the period as a consequence of a substantial increase in ambulance patient handover delays across Wales.

472. Although fire and rescue services were not used at scale, given that 999 call activity fell significantly in the early stages of the pandemic (and additional capacity was not required), this was a successful outcome with some 450 firefighters and other staff volunteering to drive ambulances.

473. Additionally, MACAs were developed by Welsh Ambulance Service and approved by the Welsh and UK Governments for deployment of military staff to support with emergency ambulance response on occasions of extreme pressure over the course of the pandemic period. A copy of the Welsh Ambulance Service MACA approved by the Welsh Government is exhibited in **AGM3WGO01/175 - INQ000227006.**

474. The Emergency Ambulance Services Committee ambulance commissioning team also engaged third sector providers to increase capacity to respond to non-emergency incidents including non-injured fallers over the relevant period.

475. The Welsh Government has established two ambulance response targets in Wales:

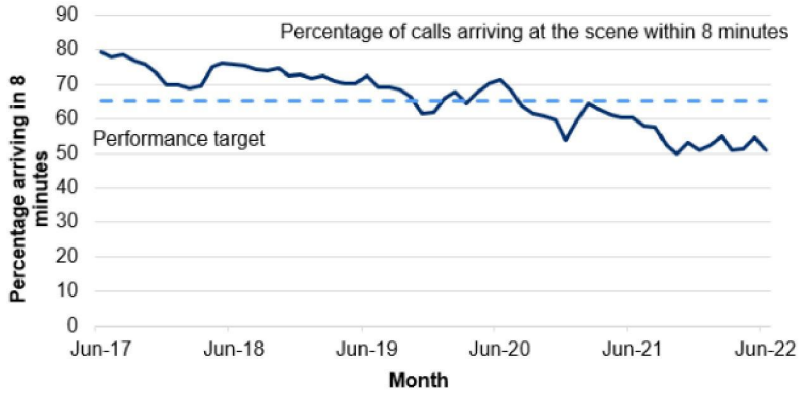
a. Red Calls (Immediately Life-Threatening): The all-Wales target is for 65% of these calls to receive an emergency response within 8 minutes. This category includes situations where someone is in imminent danger of death, such as a cardiac arrest.

b. Amber Calls (Serious, but Not Immediately Life-Threatening): There is no specific target associated with response times for amber calls.

476. In March 2020, there were 37,568 emergency calls to the ambulance service of these 2,620 were classed as the most serious (red) calls. The average daily number of emergency calls was 1,252 per day, up from 1,241 in February 2020. The average daily number of red calls in March was 87, up from 76 in February and up from 67 in February 2020.

477. A spreadsheet setting out the emergency ambulance calls and responses to red calls, by local health board and month covering the relevant period is exhibited in **AGM3WGO01/176 - INQ000227407.** The chart below summaries this information and shows the percentage of red calls across Wales which received an emergency response at the scene within 8 minutes of the patient location and chief complaint being established. This data is sourced from the Welsh Ambulance Services Trust and covers the period June 2017 to June 2022.

Figure 8 Percentage of 999 calls within national targets



Source: Welsh Ambulance Services NHS Trust (WAST)

478. There are several reasons associated with deterioration in emergency ambulance responsiveness including but not exclusive to the following:

a. An increase in ambulance patient handover delays caused by poor patient flow through the hospital system creating blockages in Emergency Departments. This causes delays in transferring patients from ambulance vehicles to the care of hospital staff and limits the available resources in the community to always respond quickly;

b. An increase in 'red (immediately life-threatened)' category patients and 'amber (serious but not immediately life-threatened)' patients which limits available capacity;

c. A reduction in available capacity caused by the requirement to deep clean vehicles at Make Ready Depots following conveyance of patients to hospital; and

d. High sickness absence rates caused by a range of factors including Covid-19.

479. It is important to note that as the spreadsheet exhibited above in AGM3WGO01/176-INQ000227407 shows there were regional variations throughout the period.

480. In order to address the deterioration in emergency ambulance responsiveness the Welsh Government worked to ease pressure on emergency departments during the pandemic by promoting a 'phone first' plan. The NHS Wales Covid-19 operating framework for quarter 2 which I issued on 18 June 2020 required health boards to

consider developing plans for a phone first before attending emergency department model. The Minister for Health and Social Services subsequently released a written statement on the 21 July 2020 setting out the intent to redesign the urgent emergency care system with a phone first approach as a key facet of the new delivery model. Under this approach, patients would call a central call handing facility to be signposted to self-care, community services or booked into an emergency department appointment as appropriate. A copy of this statement is exhibited in **AGM3WGO01/177 - INQ000227379.** A National Phone First Group was set up to deliver this and worked closely with WAST and NHS 111 to do so. A copy of the groups terms of reference is exhibited in **AGM3WGO01/178 - INQ000227206.**

481. The 'phone first' model built on concerns expressed during the early stages of the pandemic about patients presenting too late at Emergency Departments to optimise their outcome. While there were isolated reports of patients with serious conditions not seeking timely help the input from the NHS suggested the reduction in attendances over the course of the pandemic was mainly in relation to 'low risk' patients, who could be safely managed in the community through alternative services.

482. In June 2020, activity began to return to the 'normal range' and, although there was variation locally, local health boards were increasingly beginning to see rising pressure and activity in Emergency Departments. Some local health boards had begun to report long queues forming outside departments due to reduced capacity within the department, in compliance with bed spacing and physical distancing guidance. The Royal College of Emergency Medicine (RCEM) and the Royal College of Physicians also expressed concern about the safety of patients and staff, should Emergency Departments become overcrowded during the course of the pandemic.

483. The National Programme for Unscheduled Care supported the NHS in Wales to develop a 'phone first' concept. Under the emerging 'phone first' model, patients who have a life threatening or life changing emergency would continue to be advised to dial 999. People who are unsure of which service to access when they have non-life threatening nor serious complaints would be encouraged to contact either 111 (in areas where 111 is established) or a newly identified number.

484. The 'phone first' model was intended to optimise outcomes and experience by:

e. Enabling those with life-threatening and serious complaints to be triaged, assessed and treated immediately within the Emergency Department to optimise outcomes;

f. Ensuring patients who require some form of urgent medical care within hours (not immediately) are referred to secondary care / specialty advice quickly, avoiding the need to visit the Emergency Department; or booked into an appointment within Emergency Department;

g. Ensuring patients with less acute injuries or medical complaints can be booked into an appointment at a Minor Injuries Unit;

h. Enabling people with non-acute and non-medical needs to be signposted d)to the most appropriate service for their needs, first time (e.g. support for emotional distress, substance misuse support services etc.)

485. In developing plans to deliver a 'phone first' model, local health boards were asked to ensure there was sufficient primary and community care capacity and alternative services /pathways across the system to manage patients whose condition do not require attendance at an emergency department. This needed to include links to social care and third sector support services. This is reflected in the 'six goals for urgent and emergency care' policy approach communicated to local health boards and partners through the NHS operating framework for Quarter 2.

486. The Welsh Government did not receive regular data reports on NHS 111 staff capacity in 2020. This was held by the NHS 111 Wales programme team and WAST as provider of the service. Data on activity during week up to 1 March 2020 was held by NHS 111 Wales programme team and Welsh Ambulance Service. The Welsh Government started receiving daily returns from the NHS 111 Programme team from January 2021. This data only covered those NHS organisations who had implemented NHS 111 in their area. NHS 111 Wales was not a national service during the vast majority of the pandemic period, it has since expanded to provide national coverage (as of May 2022).

487. Expanding 111 capacity is / was the responsibility of the NHS 111 Wales programme team and Welsh Ambulance Service who will hold information on capacity levels and efforts to increase capacity throughout the pandemic. As outlined above, the Welsh Government encouraged health boards to develop 'contact first' services at the outset

of the pandemic. This approach was intended to encourage people who may have an urgent care need to dial 111 or contact a single point of access to determine whether assessment at an Emergency Department was required and, in the event that this was necessary, to schedule an appointment at the Department. This was intended to reduce crowding in Emergency Departments and reduce the risk of spread of infection. All health boards initially developed plans to deliver 'contact first' services but only Cardiff and Vale University Health Board delivered the approach successfully with other health boards developing variations of remote hubs where clinicians streamed patients to the most appropriate service following assessment by telephone. The health board would hold data on whether patient safety concerns emerged as a result of the change to this model.

Field hospitals in Wales

Decision to create field hospitals in Wales.

488. A field hospital is a temporary, self-contained, self-sufficient health care facility. It can be rapidly deployed for a specified period, and its capacity expanded or contracted to meet immediate emergency requirements. As with other health care services in Wales, field hospitals fall within the Welsh Ministers' responsibility to promote and provide a comprehensive health service. However, as outlined above, the Welsh Ministers delegated to local health boards, in relation to their local area, responsibility for functions under the 2006 Act,[75] including the Welsh Ministers' general duty to continue to promote and provide comprehensive health service in Wales. The decision to create field hospitals in each local health board area was therefore made by each health board taking into account the local population needs for their area and the anticipated impact of the virus on capacity levels in their local area.

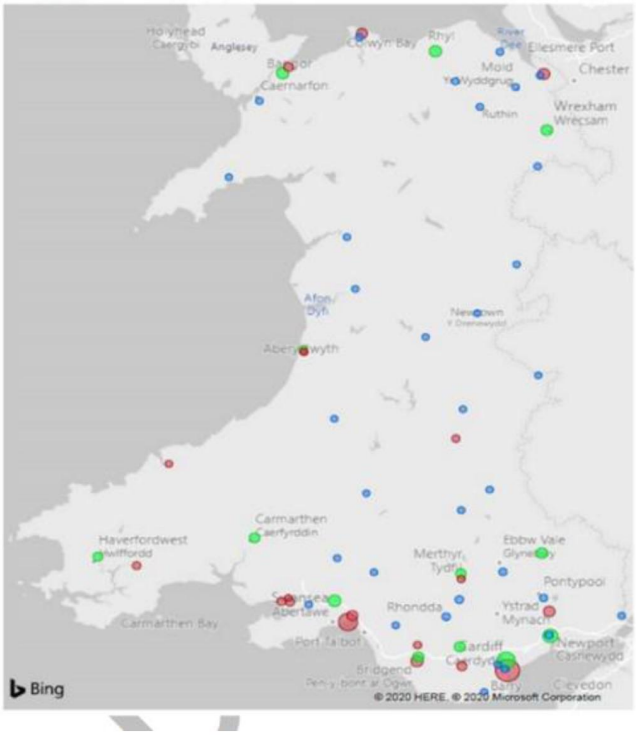
489. Within a matter of 8-10 weeks local health boards reported that 6,000 beds had been created to support the Covid-19 response in Wales. These were a mix of "theoretical and functional" surge capacity beds. Functional capacity referred to capacity where all elements required to deliver care to a patient are present when needed. This primarily consists of three pillars: Staff; Equipment; Consumables. If they are not all present, then

[75] See Schedule 1 of Local Health Boards (Directed Functions) (Wales) Regulations 2009/1511

the capacity is 'theoretical'. The Welsh Government does not have information on the number of functional beds but the local health boards were committed to maximizing acute and community hospital capacity before admitting patients to field hospital environments. The need for functional beds to be put in situ was assessed at a local level taking into account the level of demand in the local area. Any plans regarding staffing would be managed locally by the individual health boards.

490. Figure 9 below illustrates the location of each acute district general (green), community (blue) and planned field hospital (red) during April and May 2020.

Figure 9 – location of field hospitals in Wales as at June 2020



491. Field hospitals were planned at various points during the pandemic period in the following local health board area in Wales:

a. Betsi Cadwaladr University Health Board

i. Venue Cymru in Llandudno (Ysbyty Enfys Llandudno)

ii. Bangor University's Canolfan Brailsford sport and leisure centre (Ysbyty Enfys Bangor)

iii. Deeside Leisure Centre (Ysbyty Enfys Glannau Dyfrdyw)

b. Cardiff and Vale University Health Board
    iv. Ysbyty Calon y Ddraig
    v. Lakeside (a surge capacity wing added to University Hospital of Wales)
c. Cwm Taf Morgannwg University Health Board
    vi. Ysbyty'r Seren
    vii. WRU resource centre
d. Hywel Dda University Health Board
    viii. Bluestone Wales resort in Pembrokeshire (Ysbyty Enfys Carreg Las)
    ix. Cardigan Leisure Center
    x. Plas Crug Leisure Centre Aberystwyth
    xi. Parc Y Scarlets stadium
    xii. Parc Y Scarlets training barn
    xiii. Selwyn Samuel Centre in Llanelli
    xiv. Ysgol Penweddig in Llanelli
    xv. Llanelli Leisure Centre
    xvi. Carmarthen Leisure Centre
e. Swansea Bay University Health Board
    xvii. Bay field hospital, Swansea
    xviii. Llandarcy Academy of Sport

492. Neither Aneurin Bevan University Health Board nor Powys Teaching Health Board had field hospitals. Additional funding was requested from the Welsh Ministers by Aneurin Bevan University Health Board to enable it to open the Grange University Hospital in Cwmbran ahead of schedule to provide the additional capacity required in the local area. Powys Teaching Health Board, which is unique in that it does not have an acute district general hospital, made arrangements to support capacity demands in Powys by using services in neighboring health boards in Wales or in England via arrangements commissioned by Powys Teaching Health Board. This was consistent with pre-pandemic arrangements and therefore residents in the local area were already accustomed to receiving acute hospital care outside the local health board area.

493. The need for and use of field hospitals was reviewed throughout the pandemic period by the local health boards. By the end of September 2020 ten field hospitals across

four of the health boards in Wales were retained. By the end of 2020 only four field hospitals were operational these were Yybyt Enfys Deeside (Betsi Cadwaladr University Health Board), Ysbyty'r Seren (Cwm Taf Morgannwg University Health Board) and Bluestone and Selwyn Samuel (Hywel Dda University Health Board).

494. The success of measures taken by the Welsh Government to manage the outbreak, including lockdown, social distancing and shielding of vulnerable people, ensured capacity in acute and community hospital settings were not compromised and reliance on the use of field hospitals was therefore limited.

Rationale for the creation of field hospitals in Wales and how the number and location of field hospitals were determined

495. At the outset of the Covid-19 outbreak in the UK (February 2020), early models predicted a potentially catastrophic shortage of hospital bed capacity should the 'reasonable worst case' (RWC) scenario materialise. Modelling was informed by Imperial College London and the experience in Wuhan, China and Italy. Health boards were asked to plan for an increase in national bed capacity of up to 10,000 beds and up to 900 intensive care beds. The option of a larger 'Nightingale style' central hospital, as established in England, was considered but (through discussion between officials in the Welsh Government and the local health boards) discounted partly due to concerns about ensuring equity of access from across Wales and concerns about patient outcomes associated with longer transfers. Instead local capacity assessments provided for each health board area based on population share of the national modelling for Wales enabled each local health board to assess the anticipated RWC and the local population need for their area. Each health board developed its own local plans for building the extra surge capacity required either by using existing hospital sites, private healthcare providers or through the creation of field hospitals.

496. A military adviser was assigned to the Planning and Response Group and from the beginning of April two military advisers were assigned to each of the health boards in Wales. These military liaison officers provided support and practical expertise to health boards to identify suitable sites and develop specifications, which varied between health board areas.

497. Local health boards also worked with their local partners (meaning local authorities and Local Resilience Forums) to develop local proposals for field hospitals in their area. This work was taken forward as part of the health board capacity planning and therefore modelling of supplies, equipment and staffing were all determined by the local health board based on the local requirements.

498. As outlined at the start of this statement, the Welsh Ministers (acting through the Health and Social Services Group within the Welsh Government) maintained financial duties and oversight powers (linked to powers to intervene if health boards were not performing their functions) in relation to the health service in Wales. On the 16 April 2020 I wrote to NHS bodies about capacity and their use of field hospitals. A copy of this letter is exhibited in **AGM3WGO01/179- INQ000395667.** Wales was at this time already in the first peak and we were to a large extent managing within surge capacity that was developed in NHS settings. Health boards were asked to consider adjusting their initial requirements for field hospitals in the context of their broader capacity plans. If a local health board decided to continue with the planned approach to field hospitals, I asked that they ensure the Welsh Government was provided with the required clinical, service and financial details to enable formal support for the work from the Minister via Ministerial Advice.

499. A number of Ministerial Advice sought this formal support for field hospitals through the approval of funding, written statements, reviews and updates, however the operational control and decision making over field hospitals, including staffing matters all rested with individual local health boards. Taking the example of the Dragon's Heart Hospital in Cardiff, this was led by Cardiff and Vale Health Board and the plans summarised to myself and the Welsh Government at the end of March 2020, exhibit **AGM3WGO01/180 - INQ000227060** refers. The health board, supported by military planners, completed a rapid options appraisal led by the Director of Transformation working with the Medical Director, Nursing Director and Chief Operating Officer within the health board. A Strategic Co-ordinating Group (made up of all the local health boards Executive Directors) approved the recommendation to commission the Principality Stadium for the purpose of setting up a field hospital. The Medical Director and Nursing Director agreed clinical pathways for the facility and the Nursing Director also leading on the staffing model required. The health board came to the Welsh

Government for agreement of the capital funding and revenue costs associated with running the facility once this plans were agreed. The other health board similarly discussed and prepared their local plans for field hospitals.

500. I wrote to local health boards on the 24 April 2020 (as exhibited above in AGM3WGO01/170 - INQ000395661) endorsing that health boards do not commission and operationalise field hospital capacity unless it is needed. As confirmed in this letter any such decisions were to be based on a local assessment of need across health and social care in the local area.

501. Modelling for RWCS linked to the imposition or non-imposition of non-pharmaceutical intervention (often referred to as the Covid-19 restrictions) was updated and changed throughout the period. The NHS Wales planning model, which erred on the side of caution, was revised to 5000 additional acute hospital beds and 350 ICU beds that the NHS was asked to flex up, as outlined in my letter dated 24 June 2020 and exhibited in **AGM3WGO01/181 - INQ000336843**. Advice to Ministers in February 2021 is exhibited in **AGM3WGO01/182 - INQ000136844** and outlines the rationale for changes to the RWCS as part of the wider Covid-19 response but notes no impact on NHS Capacity plans as it still did not exceed the 5000 acute hospital bed request which continued for the remainder of the pandemic period.

502. NHS capacity plans differed between each local health board area based on the local requirements and therefore field hospitals were created and closed down based on the local needs and local capacity plans. Some health board re-purposed the field hospital facilities as vaccination centers. Local health boards were provided with guidance on factors to consider when contemplating whether to maintain field hospital capacity; to 'mothball'; to potentially achieve value for money or to stand down field hospitals and enable them to be returned to previous use. These factors included:

    a. How, when and at what pace restrictions on life are eased and the impact of this on transmission and infection rates;

    b. The impact of nosocomial guidance on capacity in acute and community hospitals;

    c. Pressures within social care and outbreaks within care homes;

d. Occupancy levels within acute care settings;

e. The re-emergence of routine / planned non-COVID-19 NHS activity;

f. A return to 'normal' levels of urgent and emergency care demand,

g. Changes in modelling scenarios as modelling assumptions became firmer

h. The rate limiting factors that affect the pace and scale at which these facilities could be operationalised, such as the ability to staff and equip field hospitals; and

i. the situation regarding oxygen provision and the ability to administer it.

503. Local health boards were expected to take these factors into consideration as part of their capacity planning ensuring field hospitals were operationalised only when needed.

Health care services provided at field hospitals in Wales

504. The decision to use field hospitals in Wales principally as 'Step-down' facilities was one taken by the individual health boards. The National Field Hospital and Surge Facilities Support Group (which I detail further below) produced a document intended to support local planning and delivery on the 13 April 2020, a copy of which is exhibited in **AGM3WGO01/183 - INQ000227055.** The document described the 'mixed step-up and step-down clinical/care model' for field hospitals, which required an expansion of maximization of ICU and acute capacity on existing acute hospital sites and an expansion of 'step-down' capacity in field hospital and surge capacity facilities to enable transfer of patients from acute wards to continue their recovery. The document pointed to the benefits of this model as compared with the 'ICU model', such as that used at the London Excel Centre Nightingale hospital: safeguarding essential ICU and acute capacity, improved ICU flow (where the expanded existing ICU capacity was able to hold its own), easier management, supply, distribution and re-allocation of resources and better suitability for patients of lower acuity being cared for by staff with more general skills, including those returning and emergency registrants. It noted that this approach, which was gaining momentum across the UK, was broadly clinically supported and was the model likely to be adopted by local health boards based on

their initial submissions. This was the model that was predominantly used in Wales and as noted in this document confirmed as the preferred approach by the local health boards in the initial plans and discussed as part of the NHS lead national field hospital and surge facilities support group.

Monitoring of field hospitals and challenges faced in making effective use of field hospitals

505. As outlined at the start of this statement, the Welsh Ministers (acting through the Health and Social Services Group within the Welsh Government) maintained financial duties and oversight powers (linked to powers to intervene if health boards were not performing their functions) in relation to the health service in Wales. The Welsh Government monitored field hospitals as part of the broader monitoring of health board performance during this period. Ensuring NHS capacity requirements could be met was a key factor in the Welsh Government's response to the pandemic. The reporting route for field hospitals, and broader additional/surge capacity requirements beyond field hospitals, was through the Acute Secondary Care Sub-group chaired by Chris Jones and Andrew Sallows. The terms of reference for this group is exhibited in **AGM3WGO01/184 -INQ000226938.**

506. In April 2020 Stephen Harrhy, the Director of the National Programme for Unscheduled Care for the NHS, began chairing a National Field Hospital and Surge Facilities Support Group to enable greater co-ordination of support for local health and care communities as part of the planning process for the new facilities. The terms of reference for this group are exhibited in **AGM3WGO01/185 - INQ000227073.** The Group met fortnightly between April and June 2020 and as noted above reported to the Health and Social Services Group Covid-19 Planning and Response Group, via the Acute Secondary Care Subgroup.

507. The National Field Hospital and Surge Facilities Support Group was a forum to discuss some of the challenges but the focus was more on strategic challenges rather than day to day operational matters. By way of example strategic challenges reported by the Support Group to the Welsh Government included:

    a. Impact of negative media due to a misinterpretation of the purpose of field hospitals, with suggestions they were being utilised as temporary morgues;

b. Criticism addressed to health boards of the value for money;

c. The length of tenancy agreements at some field hospital sites as these were intrinsically linked to easing of restrictions on life e.g. return of sport and arts and how this impacted the use of leisure centres and community buildings.

508. Local health boards were keen for Welsh Government communications to support to explain the role and remit of the field hospitals across Wales and reassure the public, staff, Welsh media and politicians about the new facilities.

509. The extent to which field hospitals were required and used varied between health boards and in terms of operational challenges faced in making effective use of these temporary hospitals or arrangements for admission or transfer from mainstream hospitals to field hospitals the individual local health boards hold this information.

510. Once field hospitals had been established across Wales, there was agreement by the health boards to stand down the National Field Hospital and Surge Facilities Support Group in June 2020. A Field Hospital Operational and Clinical Leads Peer Group was established in its place and operated through the summer of 2020 on an informal basis and then stood down in July and was reconvened in November 2020. The Group, which included representatives from all NHS Wales organisations with field hospitals facilities, met fortnightly to share situation reports, lessons learnt, best practice points and to escalate risks where necessary. Welsh Government Officials also conducted weekly 1:1 meetings with health board field hospital leads, where a facility was open and receiving patients.

511. A number of assurance reviews were undertaken in relation to field hospitals. A high-level paper was compiled and reflected on the planning, development and delivery of field hospital facilities as at June 2020 and the direction of travel for their use, based on the latest available predictive data modelling for future activity, exhibit **AGM3WGO01/186-INQ000227392** refers. I have included in this section of my statement some of the data from this report, but in summary it concluded the planning response to identify and secure premises and equip field hospitals with 6,000 beds within a matter of 8-10 weeks was highly commendable and a testament to collaboration across local health boards, Local Authorities and the military.

512. On 24 November 2020, Simon Dean, Deputy Chief Executive of NHS Wales wrote to local health boards to seek assurance about the quality and governance regarding field hospital environments and provided a 'Field Hospital governance checklist' to assist health boards with their local planning arrangements to help ensure a consistent approach across Wales. A copy of this letter is exhibited in **AGM3WGO01/187 - INQ000227272** and the checklist in **AGM3WGO01/188-INQ000227273.** The letter noted that only one health board had responded to a similar letter on 13 October 2020. All local health boards with plans to open (or with already established) field hospital facilities responded to the Deputy Chief Executive's letter by the end of December 2020 with either a completed checklist, developed in collaboration with Health Inspectorate Wales, or with copies of relevant quality impact assessment survey tools and standard operating procedure documentation for field hospital clinical models.

513. An informal briefing provided to the MHSS on 26 November 2020 is exhibited in **AGM3WGO01/189 - INQ000227274.** This gave details of my June 2020 letter described above and a brief update on the status of each field hospital which was in place or operational at the time.

514. Data was captured by local health boards on all patients admitted to a field hospital / temporary facility during the pandemic period. The field hospitals were operationally managed by individual local health boards and data on capacity and occupancy data was obtained on a regional and national basis rather than hospital location. In terms of numerical data of how many patients were admitted to field hospitals for the relevant period, the Welsh Government did not request this information from the health boards as distinct from the admission data. Therefore, data for field hospitals was published as part of the NHS activity and capacity during the Coronavirus (Covid-19) pandemic as exhibited in **AGM3WGO01/190 - INQ000353489** and is included in the data set out above. Data on bed status was collected by local health boards and presented in the form of a Summary Report as exhibited in **AGM3WGO01/191 - INQ000353007** which set out the bed occupancy for critical care and surge beds in use for each health board. In terms of numerical data of how many patients were admitted to field hospitals for the relevant period, the Welsh Government did not request this information from the health boards (as distinct from the admission data set out above).

The field hospitals were operationally managed by individual local health boards and data on capacity and occupancy data was obtained on a regional and national basis rather than hospital location.

515. Data was also captured on the Covid-19 status of patients in line with reporting for acute and community hospital sites i.e. "suspected, confirmed or recovering" (or non covid patient). This included any admitted to field hospital facilities. No analysis was undertaken by the Welsh Government on admission data and whether the nature of those patients' admitted to field hospitals conditions differed from patients admitted to acute or community hospital beds. However, as noted in paragraph 454 of this statement field hospitals did not provide critical care or acute care to Covid-19 patients and were used on the step down pathway.

516. The success of measures taken to manage the outbreak of Covid-19 - including 'lockdown', social distancing and sheltering of vulnerable people - ensured capacity in acute and community hospital settings were not compromised. The Welsh Government's framework for decisions to temporarily suspend routine elective procedures; a significant reduction in presentations at, and admissions via, Emergency Departments; and improved flow through hospital systems and transfer of patients to the community also contributed to unlocking significant numbers of beds. These significantly reduced demand and activity levels ensured that field hospital provision was not required to the anticipated levels even though Covid-19 patient volumes were at times significant.

517. Both the Welsh Government's internal audit service and NWSSP separately undertook a review of the use of field hospitals during the pandemic period. A copy of the Welsh Government internal audit report is exhibited in **AGM3WGO01/192-INQ000022593.** The audit recommended that a central log/chronology for field hospitals should be developed and this is exhibited in **AGM3WGO01/193-INQ000399063.**

518. Bed occupancy levels at acute hospital sites in Wales have largely remained at around 85-90% over the course of the pandemic, comparing favourably to pre-pandemic occupancy levels that were regularly around 100%.

519. As a consequence, volumes of patients admitted to field hospitals remained relatively low. Very much in hindsight, given the reasonable worst-case scenario and the ongoing uncertainty about the impact of new variants over the course of the relevant period, this is considered a positive, however as outlined above this does not diminish the very legitimate concerns at the time around capacity and the implications of what the modelling was suggesting for Wales.

Costs to the Welsh Government in setting up, operating and decommissioning such hospitals

520. The initial anticipated costs of the field hospitals in Wales are set out in the table below:

Table 10: Field Hospital estimated costs

Field Hospital Set Up	Estimated Capital £m	Estimated Revenue £m
Aneurin Bevan	5.869	0.000
Betsi Cadwaladr	0.018	25.693
Cardiff & Vale	3.062	69.170
Cwm Taf Morgannwg	2.020	5.070
Hywel Dda	4.458	8.974
Powys	0.000	0.015
Swansea Bay	1.134	32.442
Estimated Cost Total	16.561	141.364

521. In total £166 million was initially allocated to health boards in respect of field hospitals during the pandemic period. Capital funding provided for field hospitals in 2020-21 was £50 million, plus £10 million for the early opening of the Grange Hospital in Aneurin Bevan University Health Board. In addition to this, there was £83 million spent on works across the estate - some of which would have been used for field hospitals. Revenue costs linked to field hospitals was £136 million - split £101 million set-up costs, £23 million decommissioning and £12 million consequential losses.

Critical Care Capacity

522. Prior to the pandemic period work had been undertaken by the Health and Social Services Group on producing draft guidance for health boards on critical care escalation management of large unplanned increases in demand.

523. There were approximately 152 level 3 equivalent critical care beds in Wales as at 1 March 2020. The numbers did fluctuate depending on staff availability etc. and there was no process in place for monitoring critical care beds numbers and occupancy accurately prior to the introduction if the Covid-19 SitRep reporting from 24 March 2020.

524. In a letter issued by Chris Jones, DCMO(W) and Jean White, CNO(W) dated 28 July 2020 a summary of critical care occupancy was provided and which clearly demonstrates that even though we were unable to manage the expansion to 900 critical care beds originally mentioned as a planning assumption at no point during the first wave did we breach. A copy of this letter is exhibited in **AGM3WGO01/194-INQ000227245** and the annexes exhibited in **AGM3WGO01/195 - INQ000227232 AGM3WGO01/196 - INQ000227233** and **AGM3WGO01/197 - INQ000227244.**

525. The available capacity peaked at 425 beds on 9 April 2020 and occupancy peaked at 216 beds on 17 April 2020. This data was taken from the SitRep report covering the period 4 April 2020 to 17 October 2020. In the 2nd Wave, capacity peaked at 301 beds on 12 November 2020 and occupancy peaked at 234 beds on 10 January 2021. This data was taken from the SitRep reports covering the period 19 October 2020 to 29 December 2020 and covering the period 29 December 2020 to 28 February 2021. During the 3rd Wave, capacity peaked at 234 beds on 8 September 2021 and occupancy peaked at 195 beds on 9 November 2021. This data was taken from the SitRep report covering the period 30 August 2021 to 29 October 2021 and covering the period 30 October 2021 to 29 December 2021

526. Mutual aid was provided to health boards who initially struggled with critical care capacity, such as Aneurin Bevan University Health Board for example. Initially this was in the form of additional staff and equipment but later developed into transfer of patients. Guidance on preparing for the second wave was issued in July 2020 including lessons learnt form the first wave. A copy of this guidance is exhibited in **AGM3WGO01/198 - INQ000227419.** Key learning points included:

a. The importance of teamwork;

b. The need to start preparing early;

c. The value of non-invasive ventilation units;

d. The need for management support and leadership, including the importance of adequate consultation before the introduction of changes;

e. The importance of communication, for example through representation of critical care staff at key meetings, through daily safety huddles and debriefs and by addressing issues which could hamper communication such as IT security and PPE;

f. The sharing of learning;

g. The need for prompt and sufficient training for support staff and the maintenance of competence levels;

h. Infection prevention and control, with concerns expressed about lacking or unsuitable PPE;

i. The importance of psychological support;

j. The need for sufficient supplies of equipment and medicines, with shortages in some areas requiring the use of inferior substitutes or requesting supplies from other hospitals; and

k. Step down from critical care could be improved in some hospitals.

527. In addition, guidance on mutual aid support and transferring patients (exhibited in **AGM3WGO01/199 - INQ000081877)** was developed and introduced including the transfer of critically ill patients to support capacity, those transferred were generally non-Covid-19 patients. The guidance defined five levels of 'CRITCON' status to guide escalation levels:

> **CRITCON 0** (normal – 'business as usual'): normal status, able to meet all critical care needs without impact on other services.

CRITCON 1 (low surge – 'bad winter'): usual funded critical care capacity full, with some non-clinical transfers.

CRITCON 2 (medium surge – 'unprecedented'): overflow into quasi-critical care areas (e.g theatre recovery), high level of non-clinical transfers. local health boards beginning mutual aid.

CRITCON 3 (high surge – 'full stretch'): expansion into non-critical areas (e.g. wards) and/or use of paediatric facilities for adult critical care. local health boards operating at or near maximum physical capacity. Maximum mutual aid between local health boards with Wales Critical Care and Trauma Network and Welsh Government coordination. The prime imperative is to prevent any single Health Board entering CRITCON 4.

CRITCON 4 (triage – 'Emergency'): resources overwhelmed and possibility of triage by resource. This must only be implemented on national directive from the Welsh Government.

528. The guidance provided that, in order to maximise capacity before any mutual aid was considered, health boards should enact the following sequential steps in response to their escalating position:

a. Accelerated discharge of patients supported by positive risk taking.

b. Increased their own capacity by opening any closed wards with available staffing and equipment.

c. Postponed non-urgent elective care including outpatients to enable the release of staff and to create bed capacity to support both themselves and partner trusts in their system.

d. Re-deployed clinical staff from non-patient facing roles to support wards and stood down where possible any non-clinical time in job plans and training.

e. Reduced staffing ratios to open all on site beds following appropriate risk assessments.

529. The guidance also described twenty principles for critical care mutual aid:

1. All patients should have equitable access to critical care if required.

2. Staff are not placed under sustained, high levels of strain disproportionately between units or health boards.

3. The proposed destination hospital should be able to meet the care requirements for the individual patient transferred.

4. The transfer can take place safely, with minimal risk to the patient.

5. The only circumstances in which transfers take place is to maintain or undertake clinical activity otherwise compromised in the referring hospital, posing a risk to patient safety. The activity in question must be of sufficient urgency or importance to justify the risk to the patient proposed for transfer. Likely justifiable reasons include enabling admission of emergency patients or non-emergency surgery for potentially life-threatening conditions. The decision is made on a case by case basis by the responsible clinical team.

6. Decompression of units ensures safe provision across a system of critical care, irrespective of whether this is for COVID-19, emergencies or elective patients requiring critical care.

7. Elective activity priorities must be determined across a system and applied to the system as a whole and not as single sites.

8. Treatment strategies have changed for COVID-19, it is likely that many if not all of these patients will have a trial of CPAP prior to intubation. It is not ideal to transfer patients on CPAP due to the increased exposure risk for staff involved in transfer.

9. Intubated COVID-19 patients may have a period of respiratory and/or cardiovascular instability at the start of their treatment and this should be given due consideration when planning patient transfers.

10. If sites are not decompressed, it is likely that staffing ratios would be diluted in order to continue to deliver the different pathways on those sites or elective patients would need to be cancelled on a specific hospital or health board.

11. The pre-pandemic principles for capacity transfer (i.e. the most recent admission transferred), can no longer apply under these circumstances.

12. Transferring current, stable patients may be more clinically and ethically appropriate than the next patient accepted for critical care. Those patients remaining in high volume units may be exposed to staffing ratios below current GPICSv2 standards. Patients being transferred from a unit in considerable strain may receive better quality care and outcomes following their move to a unit under less pressure.

13. These transfers should be undertaken in a planned manner in daylight hours following agreement at the daily capacity call and using resources allocated by the Critical Care Hub as set out below:
    Once the bed availability at the referring and accepting unit is confirmed please contact the ECCH on 0300 123 2301. The ECCH will coordinate the following scenarios, please inform the desk what you require when you call.

    a. Time critical transfers as per normal process utilising the Consultant lead EMRTS Critical Care team.

    b. Utilisation of the south or north wales transfer ambulance provided with WAST (using the transfer team from the accepting or referring hospital).

    c. Provide a separate Registrar led transfer team utilising either a WAST vehicle or the transfer ambulance if available (discussed with transfer lead/EMRTS TC consultant).

    d. Plan/facilitate long distance transfers using HM67 platform with Registrar led transfer team for longer moves within and outside Wales. Ideally these moves will require advance notice the day before and will be discussed with transfer lead/ TC consultant)

14. Ambulance transfers should be the preferred mode of transfer wherever practical and possible. However, for long-range transfers (ie. those exceeding two and a half hours) transfer by aircraft should be considered.

15. The decision on appropriate patients for transfer is made on a case by case basis following discussions between clinicians within units and in the receiving unit.

16. Staff in the transferring unit clearly explain the reason for transfer with honesty to the patient and family/next of kin. There is a clear process in place for the circumstance in which a patient or their close family disagrees with such a transfer and that process is made known to the patient and their close family. ICS have published a statement1 on ethics of transferring critical care patients.

17. The shortest distances for transfers are the ideal and should be the primary intent.

18. Critically ill patients should be moved as few times as possible and critical-care-to-critical-care repatriations should only be carried out after the conclusion of a specialist episode of care in a tertiary centre, in circumstances of extreme pressure in the receiving hospital, or for some other clinical or non-clinical benefit for the patient.

19. Patients transferred between health boards for capacity reasons should ordinarily complete their critical care episode prior to repatriation at ward-level.

20. Delayed discharges are a contraindication to mutual aid transfers (ie. should be zero tolerance). Delayed transfers of care exceeding 24 hours should have been transferred out to a suitable ward area prior to transfer requests being enacted.

530. There were some clinical guidelines relating to the admission of critical care patients which were incorporated into the Covid-19 pathway. Decisions in relation to non-Covid-19 patients would have been taken in line with latest clinical guidance and subject to clinical judgement at the time, efforts were always made to identify a bed for a patient who would benefit from critical care intervention.

531. From December 2020 onwards, CRITCON levels together with the number of occupied and available critical care beds and numbers of delayed transfers of care

from critical care were recorded on the unscheduled care dashboard, and a daily critical care SITREP call to discuss demand, capacity, staffing and need for mutual aid was established and coordinated by the Critical Care Network.

532. There were no major safety incidents that we were made aware of. We shared all relevant safety notices with health boards and request they put safeguards in place, this was taken forward as part of the work of the Acute Secondary Care Planning and Response Sub-group.

533. Capacity was significantly stretched across South Wales during periods in the pandemic, notably in December 2020 and January 2021 during which time local health boards regularly reported CRITCON statuses of level 3. We were aware through the Critical Care Network that, in December 2020, Prince Charles Hospital, Cwm Taf Morgannwg, was close to declaring CRITCON 4 as all capacity had been exhausted there, but there was still limited capacity in neighbouring local health boards. We were 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 within the Health Board or from a neighbouring Health Board.

534. In late December 2020 and early January 2021, discussions were held with NHS England about cross border mutual aid, but ultimately these arrangements were not required as confirmed in a letter from the Chief Medical Officer to NHS England dated 26 February 2021, exhibited in **AGM3WGO01/200– INQ000421655**.

Limiting factors in expanding critical care capacity

535. Expansion of critical care capacity depends on many factors beyond ventilator and bed capacity. These include staff skill mix, staff absence, training, ancillary equipment (syringe drivers and patient monitors, for example) and oxygen delivery/consumption. The limiting factors in critical care evolved as we moved through the pandemic. Initially the number of ventilators were seen as a constraint as were the number of critical care trained staff especially as a number caught Covid-19 early in the pandemic.

536. As we distributed more ventilators and the number of critically ill Covid patients increased, other factors became more prevalent such as a worldwide shortage of paralytic drugs due to the significant increase in usage and demand and access to

other equipment and consumables such as syringe drivers and renal dialysis fluids. As we moved beyond the first wave and as there was a gradual return of prioritised planned care activity, staffing became more of an issue as there were less staff available to be redeployed to support trained critical care staff care for more patients.

537. Whilst there were limitations on the number of functional surge beds and capacity within some health boards for short periods, mutual aid was provided wherever possible and we are not aware of any patient who was deemed would clinically benefit from critical care not getting access to either a critical care bed or a bed providing enhanced support such as on a respiratory high care unit.

Use of the private health sector

538. Private hospital capacity was also commissioned across Wales providing additional outpatient, diagnostic and inpatient capacity for non-Covid-19 care. All contracts with the independent health sector providers were held by WHSSC and its NHS partners. It is worth noting that some NHS organisations would have already had contracts in place with some independent providers prior to Covid-19.

539. The Health and Social Services Group within the Welsh Government played no role in negotiating or agreeing the contracts with independent providers. The role of Health and Social Services Group was to support the NHS in obtaining the flexibility to utilise the independent sector in unprecedented circumstances and to ensure it was necessary. Principally this support took the form of financial support but also supporting facilitation of the arrangements at pace by requesting the Secretary of State to disapply Competition Act restrictions (as detailed below in paragraph 542).

540. WHSSC led on the contractual arrangements with independent providers commissioning the agreed services on behalf of the health boards in Wales. The response from the independent sector was professional and appropriate and helped to provide resilience in our response.

541. As noted above, while led by NHS Wales, the Welsh Ministers provided funding and supporting in ensuring arrangements could be put in place at pace. On the 25 March 2020 the Minister for Health and Social Services agreed to the sum of up to £30m funding towards the costs of commissioning additional private sector capacity, exhibit

AGM3WGO01/201 – INQ000235899 refers. The proposal was for NHS Wales to secure an agreement with all hospital providers in Wales via a single head of terms agreement with the sector, followed by individual contracts with each company. There were 6 independent in-patient facilities across Wales. All but one (St.Josephs Hospital, in Newport) are part of larger provider groups and all were included in the agreements.This mirrored the NHS England process and agreements, by which the NHS would block contract all hospital facilities including facilities, staff and equipment for a minimum period which could be extended by notice of the NHS. It involved flexible deployment of staff and equipment between the NHS and independent providers, integrating capacity into the NHS's own capacity at a local operational level (easier in Wales given the integrated system). Capacity was to be paid for on the basis of actual operating costs, rather than as a fee per activity basis, and on a not for profit basis. The agreement was also adaptable for the phases of the emergency including preparatory; urgent elective, cancer and non-COVID provision, extra-surge providing direct COVID provision and finally phased recovery. The position was regularly reviewed by WHSSC on behalf of the health boards during Covid-19, including usage and demand, and individual contracts were put in place which resulted in a phased reduction in the use of the private facilities in a planned way. The phased arrangements were designed to maximise the capacity that could be made available to the NHS at an appropriately reduced cost.

542. Part of these arrangements required Welsh Government officials to work with the UK Government to disapply Competition Act restrictions from agreements between NHS Wales and independent healthcare providers to manage Covid-19. An order was required to be made by the Secretary of State to allow NHS Wales to enter into agreements to procure additional capacity from private providers to manage the Covid-19 outbreak without infringing the Competition Act[76]. The UK Government made an equivalent order to disapply Competition Act rules for agreements in England.

543. A further £6m was approved on 3 April 2020 in relation to additional Mental Health Beds, as exhibited in **AGM3WGO01/202 - INQ000136777**. All relevant finance groups

[76] The Competition Act 1998 (Health Services for Patients in Wales) (Coronavirus) (Public Policy Exclusion) Order 2020

within Welsh Government approved the Ministerial advice and the approval of the sums of up to £36m. The Welsh Government Treasury will not have been involved in any detailed analysis of these arrangements given the unprecedented situation and pace required. As part of the process to agree the allocation of £30m for the provision of independent support for core NHS services, WHSSC undertook analysis of the market, including benchmarking for prices. In relation to the £36m total approved for 2020-21, actual costs came in slightly lower at £32.799m for 2020-21, with £5.123m of that referring to the purchase of additional Mental Health beds.

544. In relation to the number of private hospitals involved in the provision of healthcare for NHS patients in Wales during the relevant period, WHSSC led this work on behalf of NHS Wales organisations and were responsible for any contracts throughout this period. No patients were treated for Covid-19 in private hospitals. Private hospitals were effectively used as 'green sites' for non-covid patients to assist with treatment capacity. Patients with Covid-19 were treated in existing NHS sites.

545. Weekly sitreps on activity were developed by WHSSC on behalf of NHS organisations for monitoring purposes and to ensure maximum usage of the capacity available. This information was not produced by or held by the Welsh Government as it was not a party to the contract arrangements. Copies were shared with officials in the Health and Social Services Group and an example to the information received is exhibited in **AGM3WGO01/203 - INQ000227253.**

546. Some NHS organisations already had contracts in place with independent providers prior to COVID-19, which would have been commissioned through the normal national commissioning arrangements in place in Wales. The NHS NCCU already had a National Commissioning Framework in place to enable available mental health beds to be secured. The Framework was used to allow additional capacity to be matched with demand. A copy of this is exhibited in **AGM3WGO01/204 – INQ000227429.** The monitoring of mental health in-patient capacity was led by the National Collaborative Commissioning Unit ("NCCU") and reported to the MHIG. An example to the information received is exhibited in **AGM3WGO01/205 - INQ000227262.**

547. Separately to the arrangements by made by WHSSC, officials, through the multi-agency Mental Health Incident Group ("MHIG"), worked with health boards to

understand the changing demand for mental health services during this period, with health boards doing what they could to reduce admissions to manage demand within their existing mental health bed capacity, the surge arrangements were put in place to provide resilience to service delivery.

548. The Welsh Government worked with NWSSP and the NCCU to fund the procurement of additional mental health in-patient capacity from the independent sector and /or third sector in Wales. Approval was provided for expenditure up to £6 million in 2020-21, exhibit AGM3WGO01/202-INQ000136777 above refers. These arrangements were led by NWSSP and NCCU.

549. As set out in the Local Health Board consolidated accounts, during the pandemic period the following allocations were made to NHS Wales for in respect of private providers:

2018 – 19	£57,095m
2019 – 20	£61,034m
2020 – 21	£77,887m
2021 – 22	£93,094m

550. These figures are the total spend and not broken down in respect of Covid and non-Covid patients.

551. Reflecting on NHS capacity and the use of field hospitals and private hospital during the pandemic period, the collective response across NHS Wales was nothing short of extraordinary. In a few weeks they more than doubled the historic critical care capacity and formed plans for additional field/surge hospitals. As noted above we were working on the basis of 40% RWCS approach and it was essential that Welsh Government had a clear understanding of the ability of NHS Wales collectively to deliver to that level over a 3-to-4-week period from March 2020 and was able to give confidence to the system about our preparations, commitment and our ability to make decisions urgently. While extreme surge guidance was drafted and rationing of intensive care considered in readiness this guidance was never finalised or issued (as detailed earlier in this statement at paragraphs 136 and 137). It was not required as we had sufficient capacity in the system. The hope was always that any additional capacity

made would be underused –which thankfully it was. The capacity used was influenced not only by the NHS preparation and plans, but also by the impact of the wider decisions made by the Welsh Government to impose restrictions and the amazing efforts of the people of Wales which prevented exponential increases in demand and patients. However, the preparation and commissioning of capacity still had to happen and the efforts of the Health and Social Services Group and NHS Wales are commendable.

Guidance to the health care system on admission to and discharge from hospital

552. The Inquiry has asked me to comment on admission to and discharge from hospital. I understand that the Inquiry has indicated that Module 3 will consider the protocols and policies relating to the admission and discharge of patients as they affected hospitals and those being treated and working in the hospitals, and the later care sector module will deal with the impact of patient discharge on the care sector[77]. While I will focus this section of my statement accordingly it is important to highlight that as we have an integrated health and social care system in Wales, decisions were taken in the context of this integrated environment.

553. To support this section of the statement I have sought information from Dr Chris Jones, the Deputy Chief Medical Officer and Albert Heaney, Chief Social Care Officer for Wales.

Welsh Government guidance on admission into hospital for general practitioners and ambulance services

554. I am asked to provide details of guidance given during the relevant period by the Welsh Government on the approach that general practitioners and ambulance services should take regarding whether to admit patients to hospital, and how this differed from any guidance in place prior to the relevant period.

555. Prior to the pandemic, the Welsh Government did not, to my knowledge, issue guidance to general practitioners and ambulance services on whether to admit patients to hospital. NHS organisations in Wales were responsible for applying guidance from professional bodies, such as, on a national level, the National Institute

[77] Module 3 preliminary hearing on 28 February 2023, Jacqueline Carey KC, paragraph 5 page 14 of transcript

for Clinical Excellence ("NICE") or the Respiratory Implementation Group in Wales. This guidance would have covered matters such as the assessment and management of patients, including those with respiratory illnesses. In doing so, the NHS bodies in Wales may develop local guidance or agree national guidance, which could take the form of a clinical pathway or continuing professional development, on the management of certain cohorts of patients. It is ultimately the responsibility of NHS organisations in Wales – and the clinicians involved in patient management – to interpret and apply any national or local guidance in the management of patients and any required admissions to hospital. This should always be based on an assessment of clinical need and on a case-by-case basis.

556. In the very early stages of the pandemic primary care and ambulance services were initially advised in relation to admission to hospital of symptomatic returning travellers, who were considered the most likely source of the entry of the virus into the UK and Wales. The CMO(W) wrote to all clinical staff on the 31 January 2020 and provided a Wuhan Novel Coronavirus Patient Flow Algorithm which also included signposting to the UK 'COVID-19: interim guidance for primary care' which was published on the 21 January 2020. A copy of the CMO(W) letter is exhibited above in in AGM3WGO01/84-INQ000048560 and the patient flow algorithm in **AGM3WGO01/206 - INQ000226918.**

557. The Primary Care guidance noted that if the patient was critically ill and required an urgent ambulance transfer to a hospital, inform the ambulance call handler of the concerns about Covid-19. In all other instances, the case must be discussed with the hospital first so that they are aware that Covid-19 is being considered and the method of transport to secondary care agreed. In addition, the Welsh Government received advice from the National Clinical Lead for Respiratory Medicine recommending collaboration with the Institute of Clinical Science and Technology ("the Institute"), based in Cardiff, to establish an online facility for clinical guidance with training video content. The majority of NHS consultants in Wales directly involved in Covid-19 care registered with this facility which was regularly updated by the Institute as evidence changed during the pandemic period.

558. Guidance on admission to hospitals was linked to concerns on the need to build urgent capacity in NHS Wales which I have outlined earlier in this statement. As noted earlier,

on the 13 March 2020 the Minister for Health and Social Services took the decision, following discussion with myself and the NHS Chief Executives in Wales, to issue an action list for them to consider and take early and decisive steps to continue to provide care and support to the most vulnerable people in our communities, whilst also making sure organisations and professionals were supported to make timely preparations for the expected increase in the number of confirmed cases of Covid-19. A written statement setting out the list of 10 actions was issued on the same date and is exhibited in **AGM3WGO01/207 - INQ000198262** and set out above in paragraph 459. In relation to admission to and discharge from hospital this was particularly significant as it enabled health boards, among other things, to suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery), prioritise use of Non-Emergency Patient Transport Services to focus on hospital discharge and ambulance emergency response and expedite discharge of vulnerable patients from acute and community hospitals.

559. As part of the HSS Planning and Response Group structure (as outlined in Part A of this statement), a Primary and Community Covid-19 Subgroup was put in place. The terms of reference for this group are exhibited in **AGM3WGO01/208 - INQ000227399** but in summary its purpose was to provide strategic co-ordination of primary and community services arrangements for Covid-19, including planning for the reasonable worst-case scenario (RWCS). This included producing or overseeing any guidance to the NHS in Wales on the management of Covid-19 in the community, including criteria for referring people with COVID-19 to hospital.

560. The Welsh Government issued the Covid-19 Primary and Community Care Guideline (also referred to as 'Framework') on 23 March 2020, exhibit **AGM3WGO01/209 - INQ000226967**. The Framework outlined the four key health care actions in the community as

    i. Self-care and self-management at home.

    ii. Supportive care delivered in the home, GP surgery or cluster hub by a multi-professional team serving a cluster population.

    iii. Palliative care delivered in the home.

iv. Referral to an acute hospital.

561. The Framework also included a section covering an ethical framework to apply when considering whether a patient requires admission. This stated that treatments should be used that work, without disproportionate harm, subject to consent or best interests judgments, and provided they can be offered within the resources available. Treatments should not be used where they do not meet these criteria, nor where they stand no real chance of working in a particular patient. It emphasised that whatever treatment was being used, each patient should be given the best care available, helping them to survive if that can be achieved and in all cases helping them to be comfortable and live with dignity. It noted that making sure patients are not given treatments which are not right for them helps them, and also helps other patients who may have a greater chance to have treatments that work: this should be the basis of decision and is the fairest way to decide when there is not enough to go around. The Framework also included guidance on the Clinical Frailty Scale.

562. When the Framework was issued on the 23 March 2020, I wrote to the health boards and WAST flagging the need to implement this framework as part of whole system working and in the context of the entire patient pathway. This entire framework/pathway was to be used by any doctor, nurse, paramedic or allied health professional, anywhere in the community. It was fully expected that health boards and primary care would plan and deliver their services differently according to local needs and workforce and would follow this framework. A copy of my letter to the service is exhibited in **AGM3WGO01/210 - INQ000226961.**

563. Updates to the framework were published on the following dates:

a. Version 2 on 1 April 2020, exhibit **AGM3WGO01/211 - INQ000227400** refers. This made small amendments including removal of palliative care advice to use airflow to the face (e.g. a fan), which was no longer advised.

b. Version 3 on 8 April 2020, exhibit **AGM3WGO01/212- INQ000227026** refers. This included guidance that the clinical frailty scale should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disability or autism, and that an

individualised assessment is recommended in all cases where the clinical frailty scale is not appropriate.

c. Version 4 on 16 June 2020, exhibit **AGM3WGO01/213 - INQ000227398** refers. This included a number of updates including the addition of Black Asian Minority Ethnic patients and those with learning disabilities to the higher risk categories, a reminder that if a patient is not suitable for ICU, they may still benefit from admission to hospital for oxygen therapy and non-invasive intervention and an additional flowchart for the management of borderline cases.

d. Replacement guidance was issued on 22 December 2020, exhibited in **AGM3WGO01/214-INQ000421651**. Key developments to the guidance, were highlighted in a Welsh Health Circular from the Chief Medical Officer on the same date, exhibited in **AGM3WGO01/215-INQ000227396.** These included:

   i. The widespread use of COVID-19 community testing, meaning that primary care clinicians are seeing more patients with proven diagnosis.

   ii. The ability to segment patients with proven or suspected COVID-19 into three risk categories with separate recommended actions.

   iii. The potential to use pulse oximetry to support self-monitoring at home for patients at moderate risk of complications.

   iv. The availability of clear thresholds for admission or staying at home with safety-netting advice.

   v. The potential for delivering point of care testing in the community for COVID-19 prior to admission in order to stream patients and reduce the risk of transmission,

564. Another key document was the Essential Services Framework which is exhibited in **AGM3WGO01/216 - INQ000226998**, and which was aligned to the NHS Wales

Quarterly Operating Frameworks which were issued during the pandemic period and which have been exhibited earlier in my statement at paragraph 202.

The Welsh Government guidance to the healthcare system on preparing patients for discharge from hospital and testing of patients prior to discharge

565. As with admission, the decision to discharge was ultimately a clinical decision. While national or local guidance on discharge was in place prior to and during the pandemic period, clinical teams were advised to ensure patients were fully suitable for discharge following a clinically-led review. This was supported by advice on decision making in acute settings, as set out in Hospital discharge service requirements: Covid-19 exhibited already above in exhibit AGM3WGO01/172-INQ000227334. It is important to note that the discharge environment was continually being shaped by multiple discussions involving a wide range of policy officials within the Welsh Government and external partners regarding topics such as discharge, testing and vaccination. These were framed to respond to the rapidly changing Covid environment and keep people, for example those in residential settings, safe. This would include making those environments safe to discharge into whilst also keeping them safe for existing residents and guidance was given to social care settings on their role in managing discharges into these settings.

566. In the period leading up to the pandemic there had been work undertaken to assess the discharge process in line with commitments made in 'A Healthier Wales'. In 2018 the NHS Wales Delivery Unit ("NHS DU") undertook a review of complex discharge across Wales based on the National Programme for Unscheduled Care ("NPUC")[78] 'Every Day Counts' programme. This included implementation of the home first ethos and Discharge to Recover then Assess ("D2RA") pathways. The NHS DU had been working to support health boards and local authorities with local implementation of the D2RA pathway and also commenced work in 2019 on 'Right Sizing Community Services for Discharge'.

567. This pre-pandemic work on discharge arrangements underpinned the Covid-19 hospital discharge guidelines. The D2RA was predicated on the evidence that hospital

[78] The NPUC is a long running programme established to facilitate and enable change and improvement for unscheduled health and care services in Wales. This Programme is overseen by the Emergency Ambulance Services Committee (EASC) which is a Joint Committee of all Local Health Boards in NHS Wales.

is not always the best place for frail people to receive services. There was evidence suggesting that hospital stays for frail people, particularly frail older people, could lead to reductions of mobility, physical and cognitive ability, loss of independence and greater reliance on long term care. The D2RA model formed the basis of the COVID-19 guidelines in order to help protect frail people from exposure to the virus in institutions and maximise capacity in service provision. A report outlining the work on right sizing community services to facilitate discharge (using the D2RA model) was published in May 2020. A copy of a joint letter to health boards, local authorities and RPBs from myself and Albert Heaney to note the publication of the report is exhibited in **AGM3WGO01/217 - INQ000227162** and the report itself exhibited in **AGM3WGO01/218 - INQ000227163.**

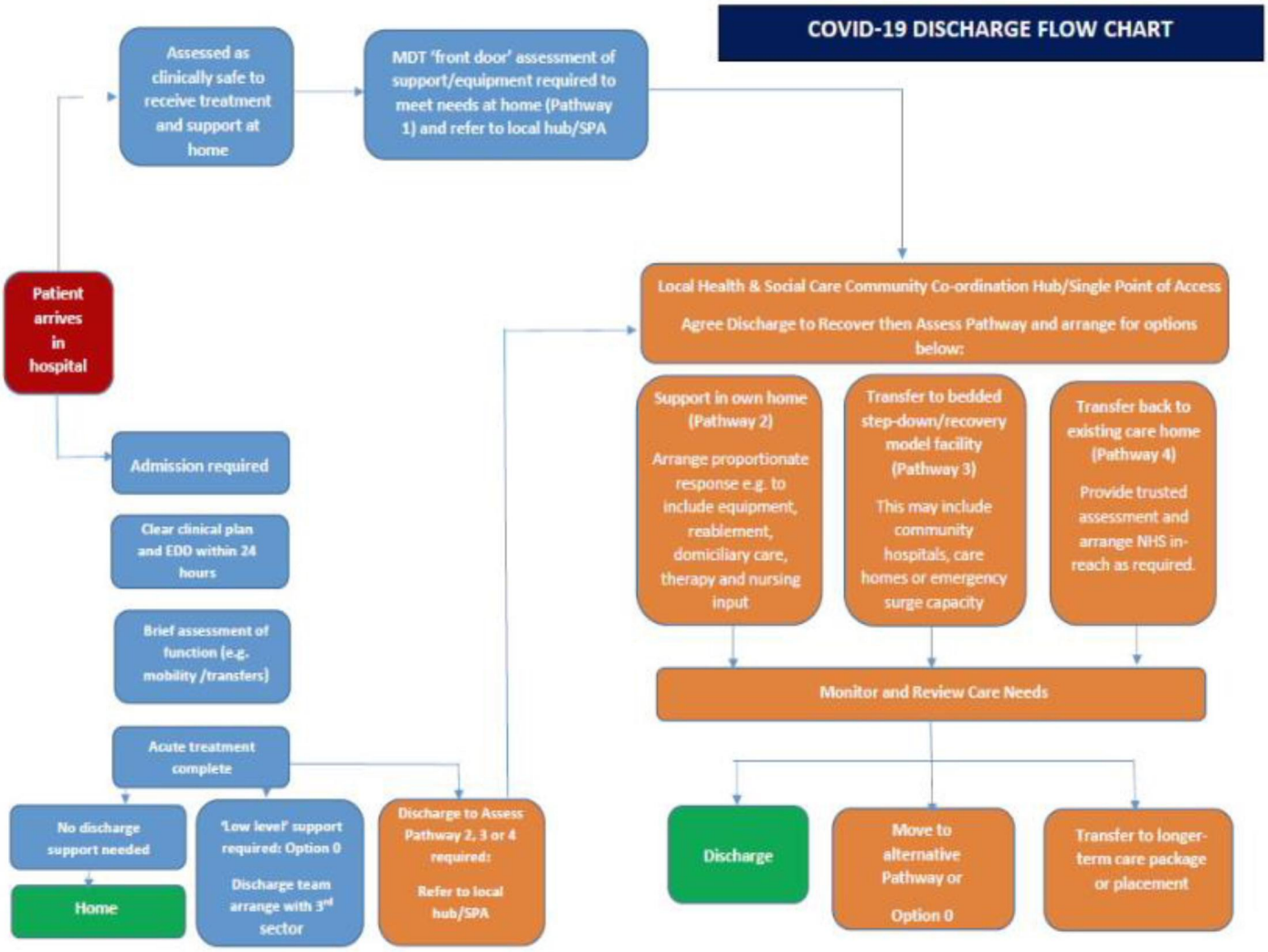
568. On the 7 April 2020, the *Welsh Government and NHS Wales Guidance: Hospital discharge service requirements: Covid-19* was published, as exhibited above. Following publication of this guidance myself and Albert Heaney wrote out to the health boards, local authorities and RPBs on 8 April 2020 to confirm the publication. A copy of this letter is exhibited in **AGM3WGO01/219 - INQ000236770**[79]**.** We highlighted that much of the content would be familiar as it was based on the D2RA pathway however, due to the Covid-19 emergency period, in order to manage discharge and hospital flow we were required to:

    a. Expedite at scale and pace services and practice development designed to assist people home, and

    b. Pool the expertise and learning at local, regional and national levels.

569. The guidance included the following flow chart in relation for Covid-19 discharge:

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



570. The guidance did not change the criteria for assessing whether a patient was medically fit to be discharged. This remained a clinical decision.

571. At the same time as this guidance, Public Health Wales also issued for the social care sector guidance on 'Admission and Care of Residents during the Covid-19 Incident in a Residential Care Setting in Wales'. A copy of this is exhibited in **AGM3WGO01/220 - INQ000227017.** This guidance outlined the vital role that the care sector plays in accepting patients as they are discharged from hospital, both because recuperation is better in non-acute settings and because hospitals needed to have enough beds to

treat acutely sick patients. It confirmed that the discharging hospital would clarify with care homes the Covid-19 status of an individual and any Covid-19 symptoms during the process of transfer from a hospital to the care home. The guidance confirmed Covid-19 tests would primarily be given to:

a. all patients in critical care for pneumonia, acute respiratory distress syndrome ("ARDS") or flu like illness;

b. all other patients requiring admission to hospital for pneumonia, ARDS or flu like illness;

c. when outbreak has occurred in a residential or care setting for example long term care facilities or prison.

572. The guidance confirmed that negative tests were not required prior to transfer of public admissions into residential settings.

573. The guidance on testing before discharge was updated on the 24 April 2020. The CMO(W) and Albert Heaney wrote out to care homes and health boards on the 22 April 2020 confirming the new policy on testing and confirming updated Welsh Government guidance to reflect these changes - *COVID-19 Hospital Discharge Service Requirements (Wales)* and *Guidance for stepdown of infection control precautions and discharging COVID-19 patients*. The letter confirmed that Public Health Wales would also be updating its guidance on the *Admission and Care of Residents during COVID-19 in a Residential Care Setting in Wales*. A copy of this letter is exhibited in **AGM3WGO01/221 - INQ000227080.**

574. The new testing policy ensured that from the 24 April 2020 all individuals being discharged from hospital to live in care homes regardless of whether or not they were admitted to hospital with COVID-19 would be tested. This included testing people who are being transferred between care homes and for new admissions from the community. These changes evolved in response to advice from Public Health Wales and concerns relating to the vulnerability to the virus of older people in care homes.

575. The CMO(W) and Albert Heaney also wrote out to Medical Directors and Directors of Public Health on the 24 April 2020 confirming the policy change and highlighting that

discharge, transfer or admission will not take place until the result of a Covid-19 test was available and has shown to be negative. A copy of this letter is exhibited in **AGM3WGO01/222 - INQ000227087**.

576. I have been asked to identify any impact that the requirement to test patients for Covid-19 prior to discharge to a care setting had on the availability of beds within hospitals. The policy to discharge patients to a care setting was developed and issued via the Population Health Directorate. At the time, there were specific bed challenges in acute hospitals given the staffing issues that were also apparent, and we knew that there remained a significant volume of patients that were medically fit for discharge (Delayed Transfers of Care as we call them) but required a care home setting.

577. I have also been asked to provide, if known, the number of instances where an individual was otherwise fit to be discharged but returned a positive Covid test. We did not hold this data, I believe only health boards would have been able to inform on these numbers.

578. On 3 November 2020, I and Albert Heaney wrote to health boards and local authorities to remind them of the need to continue to implement the Covid-19 Discharge Service Requirements. In particular, the Home First ethos, the D2RA pathways and the focus on rehabilitation and reablement. A copy of this letter is exhibited in **AGM3WGO01/223-INQ000227267**.

579. On 16 December 2020, a revised version of the guidance was published: COVID-19 Hospital Discharge Service Requirements (Wales) - Update to Guidance in respect of testing and Step-up & Step-down Care Arrangements during the COVID-19 period. This was based on advice from Public Health Wales and the Technical Advisory Group and discussion with stakeholders. A written statement was published to announce this, exhibited in **AGM3WGO01/224 - INQ000227285** and a copy of the updated guidance in **AGM3WGO01/225- INQ000227351.**

580. This update set out new testing procedures for 3 scenarios:

1) For patients with no evidence of COVID-19 who are ready for the next stage of care: discharge to an existing or new placement or care package, where the individual

has received a negative COVID-19 test result prior to discharge, with a 14-day isolation period.

2) For patients who have had COVID-19 infection, are ready for the next stage of care and are confirmed as non-infectious: discharge to an existing or new placement or care package, with no need for an isolation period.

3) For patients who have had COVID-19 infection, are ready for the next stage of care and are confirmed as infectious for COVID-19, are still symptomatic or within the 14-day initial isolation period: transfer to a 'step-down/step-up whilst Covid infectious' facility.

581. In March 2021 the 'Framework for Covid-19 testing for hospital patients in Wales' ("the Framework") was published. A copy of the Framework was exhibited in AGM3WGO01/96-INQ000081893. The Framework set out the steps to be taken in order to prevent Covid-19 entering hospitals undetected, to prevent spread within hospitals, to reduce the risk to some particularly vulnerable cohorts of patients requiring treatment and to enable the safe discharge to home or community care. In summary this Framework required:

I. Pre-admission RT-PCR testing in all patients due to be admitted for elective treatment.

II. Implementation of the 'discharge to care home' criteria of non-infectiousness for all planned elective admissions with previous history of COVID-19 infection.

III. Robust and consistent data collection of testing practice for local and national assurance.

IV. Testing of emergency admissions using LFD or suitable rapid point of care devices like Lumira DX, in addition to RT-PCR, interpreting the results in the context of the likelihood of Covid-19 infection.

V. Adherence to the NHSE standard operating procedure for emergency admissions and pathways.

VI. Repeated RT-PCR test at 5 days after an initial negative result and at 5-day intervals and consider retesting at 3 and 7 days in areas of high nosocomial transmission.

VII. Consideration of enhanced testing of patients who were clinically extremely vulnerable or receiving dialysis and cancer care in hospital.

VIII. Adherence to published Welsh Government guidance on testing prior to discharge to care homes or other health or social care facility.

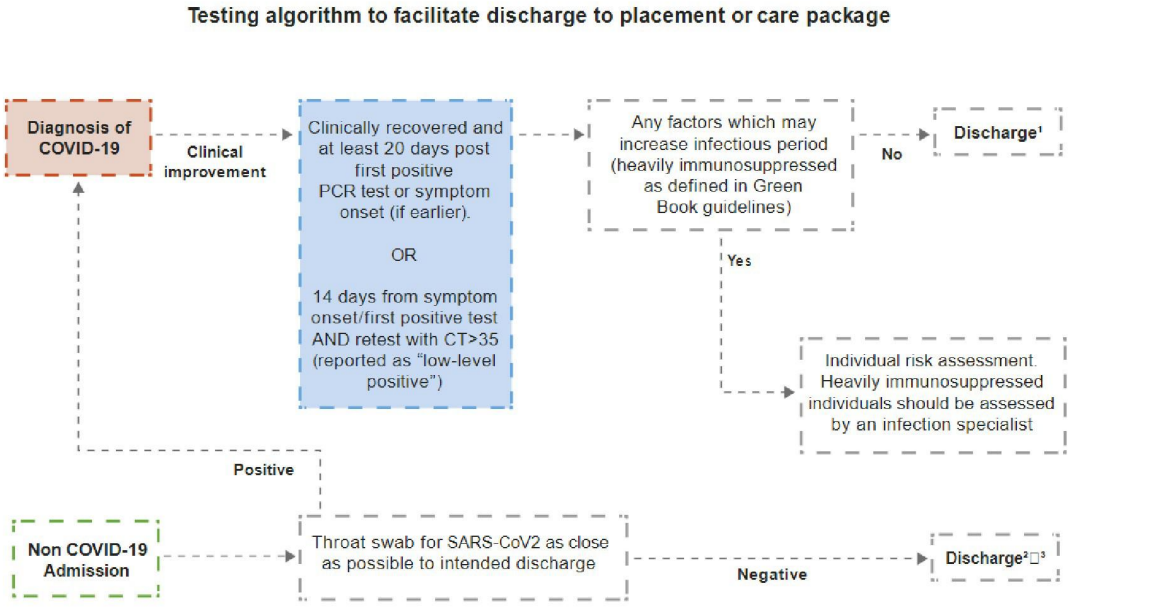
582. The requirement and prioritisation of testing patients before discharge to care homes continued throughout the pandemic period.

583. As illustrated in the 'Testing algorithm to facilitate discharge to placement or care package' flowchart published in the appendix of the framework, reproduced below, patients could be discharged from hospital to other care settings when they were either:

a. 14 days post symptom onset or first positive RT-PCR test, and a negative or low level RT-PCR result; or

b. 20 days post symptom onset or first positive RT-PCR test (whichever was earlier) without the need for further testing and regardless of any test result if a test is done.

Figure 10: 'Testing algorithm to facilitate discharge to placement or care package' flowchart



NOTES:
1. Strong clinical evidence confirms that patients >20 days post symptom onset who have clinically recovered are not an infectious risk, but may have a significant delay before they achieve a negative PCR test. Repeat testing of individuals recovering from COVID-19 greater than 20 days post onset is rarely required and a positive test >20 days post symptom onset is not a contraindication to discharge.
2. Patients discharged who have not had COVID-19 and test negative on discharge should be isolated for 14 days in their destination setting. In a care home this means all personal care is provided in an individual's own room by staff wearing PPE and the home has been risk assessed as able to meet the standards of infection control able to support the quarantine period.
3. A negative swab in an asymptomatic individual who has never had COVID-19 provides only minimal reassurance, strict IP+C precautions and isolation must be observed as the patients may still develop symptoms after discharge and transmission may occur BEFORE symptoms develop.

584. Further updates to the *COVID-19 Hospital Discharge Service Requirements (Wales)* were published to reflect the latest testing policy and scientific advice – on 25 November 2021, as exhibited in **AGM3WGO01/226-INQ000082432,** 16 December 2021 as already exhibited in AGM3WGO01/225 - INQ000227351, and 28 January 2022 as exhibited in **AGM3WGO01/227-INQ000227397.** The November 2021 update provided that: These updated the guidance in respect of patients transferring to care settings (care homes and domiciliary care at home):

585. Patients with no evidence of Covid could be discharged to care settings upon receiving a negative test result, undertaking a 14-day isolation period (reduced to 10 days in the January 2022 update) with the option to 'test to release' with a negative LFT on day 3.

586. Patients who had previously had Covid but since tested negative or a 'low positive' may be discharged to care settings with no need for an isolation period, providing the

other criteria were met: 14 days since the last positive test or onset of symptoms (reduced to 10 days in the January 2022 update), free from fever for three days and other symptoms having shown improvement.

587. In relation to patients discharged to non-care settings (for example to their own home), although they may have been tested for example as part of inpatient testing, there was no requirement in the guidance to test prior to discharge.

588. On the 24 March 2022 advice was put before the Minister recommending approval of an updated Framework for Covid-19 testing for hospital patients in Wales. This was based on input from the Testing Clinical Advisory and Prioritisation Group ("TCAP") and the NTG who had reviewed advice from Public Health Wales. The Public Health Wales advice dated 17 February 2022 is exhibited in **AGM3WGO01/228-INQ000068180**[80]**.** In respect of patients being discharged to closed settings, including care homes, the advice was for asymptomatic patients who had not previously tested positive for Covid-19 to be tested within 24 hours of planned discharge to the care facility. In the case of those who had tested positive on or since admission to hospital there could be assumed non-infectivity based on time passed since the resolution of symptoms or negative lateral flow device test results. A copy of the advice to the Minister for Health and Social Services is exhibited in **AGM3WGO01/229-INQ000136882** and the updated Framework is exhibited in **AGM3WGO01/230-INQ000262370**[81]**.**

589. On the 24 June 2022 the Testing Transition Plan confirmed Wales' continued commitment to PCR and LFD testing under the patient testing framework and when clinically advised including pre-operative hospital patients and care home residents returning from inpatient hospital stays. A copy of the Testing Transition Plan is exhibited above in AGM3WGO01/104 - INQ000227376.

590. I have been asked to comment on whether and how the pandemic affected the flow of patients through hospital and/or the ability to discharge patients, and any steps

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

taken by the Welsh Government to address this. The pandemic put extreme pressure on all parts of the health and social care system, and further compounded the long-standing capacity issues within both sectors, which has led to sustained issues in terms of hospital discharge and patient flow. Respiratory patients and specifically Covid-19 patients have a longer length of stay than general emergency admissions so the cumulation of patients during the pandemic resulted in higher occupancy levels. Delayed discharge figures as of 17 February 2022 showed that 1,081 people who could have been discharged, remained in hospital. The Welsh Government and the NHS Delivery Unit led a National Risk Summit in mid-February 2022, looking at key issues around discharges and patient flow. As a result, a system "reset" was agreed across health and social care services to support flow throughout the system and reduce the number of patients experiencing delayed transfers of care. This took place from 2 to 16 March 2022. Further work is ongoing as part of the Planned Care Recovery Plan which is the programme for transforming and modernising planned care and reducing the waiting lists in Wales.

591. As described in paragraph 427 above, the Welsh Government took steps by introducing guidance on 7 April 2020, exhibited in AGM3WGO01/172-INQ000227334, which required the expedition at scale and pace of services and practice development designed to assist people home, and the pooling the expertise and learning at local, regional and national levels. This statement also describes steps taken by the Welsh Government in relation to increasing hospital bed capacity and NHS staffing levels.

Assessment of impact of the pandemic on bed availability

592. As already outlined in the section of this statement on NHS capacity, there was a continual assessment of NHS capacity linked to the broader review on the imposition or non-imposition of non-pharmaceutical interventions and restrictions. This assessment was based on the key indicators data which outlined the Covid-19 hospital admissions, daily case rate and bed occupancy figures to provide an overview of the position in the NHS.

593. During the pandemic period the Health and Social Care Capacity: Modelling and Monitoring group was set up in June 2020 as a joint initiative led by the NHS DU and

the Welsh Government in collaboration with health and social care partners across Wales. The terms of reference for the group are exhibited in **AGM3WGO01/231 - INQ000136991**[82]. The group built on the joint intelligence gathering undertaken in relation to Covid-19 and was tasked with undertaking the following:

a. Whole system modelling of health and social care capacity required to meet the needs of people discharged from hospital following Covid-19 infection on a D2RA pathway, people with non-covid-19 conditions who require support in the community to recover from illness or the effects of shielding, people who may be affected by future surges of Covid-19 and anticipated winter pressures.

b. Monitoring the response to the identified capacity requirements and adapting in light of emerging evidence, drawing on the national health and social care data sets.

594. This group would report monthly to the National Programme Board for Unscheduled Care and the National Advisory Group for Right Sizing Community Services for Discharge.

NHS Staffing

595. The Inquiry has asked me to comment on staffing during the pandemic period, particularly in respect of the availability of staff and support that Welsh Government made available or supported the provision of by the NHS. Emma Coles, Deputy Director, NHS Workforce and Operations within the Health and Social Services Group has provided assistance with this section. I would like to say at the outset that, particularly in the first few months of the pandemic period, the health care workforce was under unprecedented pressure and, particularly in my role as Chief Executive NHS Wales, my aim throughout was to promote the welfare and well-being of our health and care staff and to plan and delver capacity and services to respond the crisis.

Availability of healthcare staff

[82] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227192]

596. During the pandemic period there was a rise in staff absences within all NHS Wales organisations. In response to the pandemic, timely management information on NHS staff absence was requested from all NHS Wales bodies to support transparency and understanding of workforce capacity.

597. Data was collected daily from 20 April 2020 (excluding Swansea Bay UHB which was not able to submit data on the same basis as the other organisations until 25 May, the Welsh Government are unclear of the reason but note this from the Stats Wales statistical quality information) until 9 August 2020, then once a week or fortnightly depending on the Covid-19 situation at the time. Data was initially submitted as part of the UK Cabinet Office return and was also shared with the Ministry of Defence.

598. In response to the Covid-19 pandemic, StatsWales published information covering the period from the 14 April 2020 on NHS staff absence to support transparency and understanding of NHS activity and capacity. Figures show the percentage of NHS staff absent due to COVID-19 related illness, self-isolation or otherwise by staff group and date. The data is taken from management information and was not subject to the same validation processes undertaken for official statistic releases. The data for the period from the 14 April 2020 – 30 May 2022 has been exported and provided as an exhibit to this statement, referenced **AGM3WGO01/232 - INQ000227409.** The charts at Figure 11 below summarises the data for staff absence and the chart at Figure 12 summarises the data for self-isolation.

Figure 11 – data for staff absence

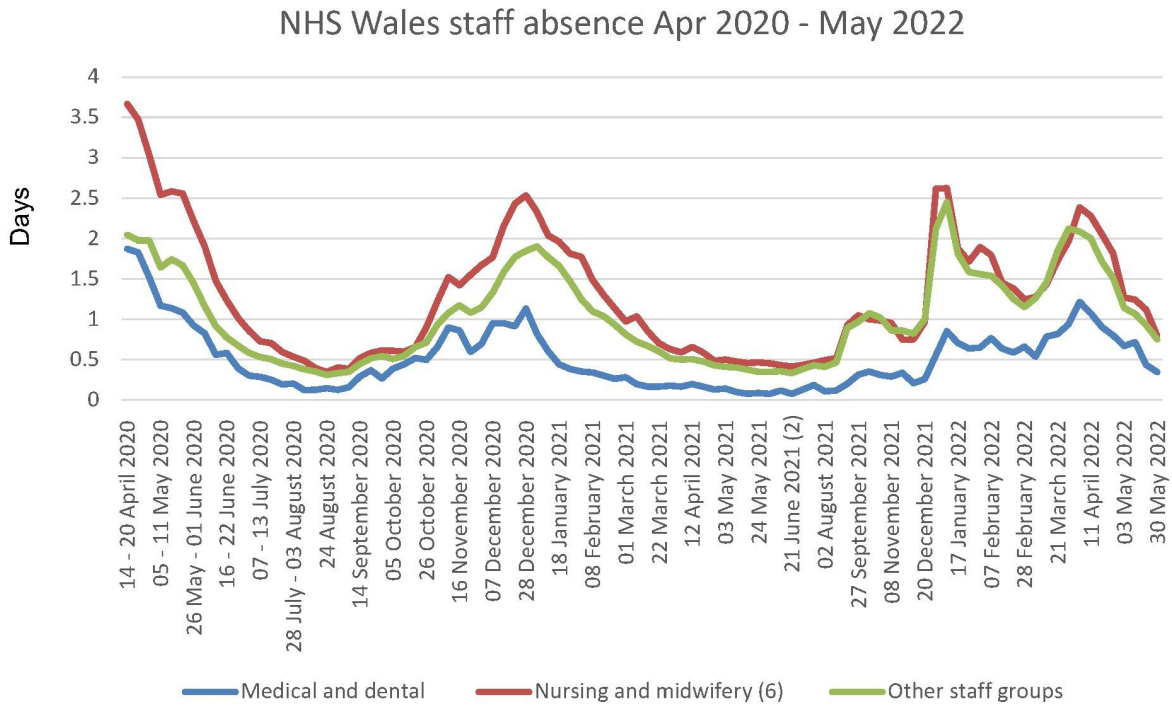
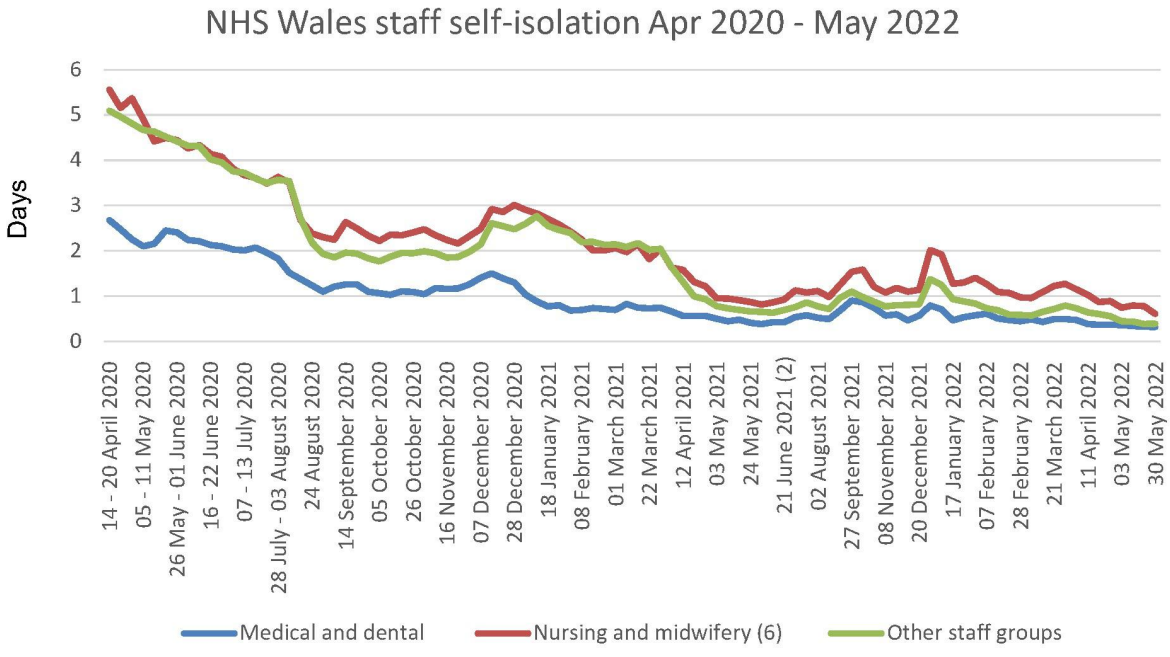


Figure 12 – data for self-isolation



599. StatsWales also published quarterly sickness absence rates for directly employed NHS staff during the course of the pandemic. Data is extracted from the NHS Electronic Staff Record. Sickness absence rates by month, quarter and year are calculated by dividing the total number of sickness absence days by the total number of available days for each organisation and each staff group. The data for the period from the January 2020 – June 2022 has been exported and provided as an exhibit to this statement, referenced **AGM3WGO01/233- INQ000227410.** The chart at Figure 13 summarises the data for sick absences by each staff group and for each quarter during 2020. Figure 14 summarises this data for 2021 and Figure 15 summarises the data for 2022 until June.

Figure 13 - data for staff sickness 2020

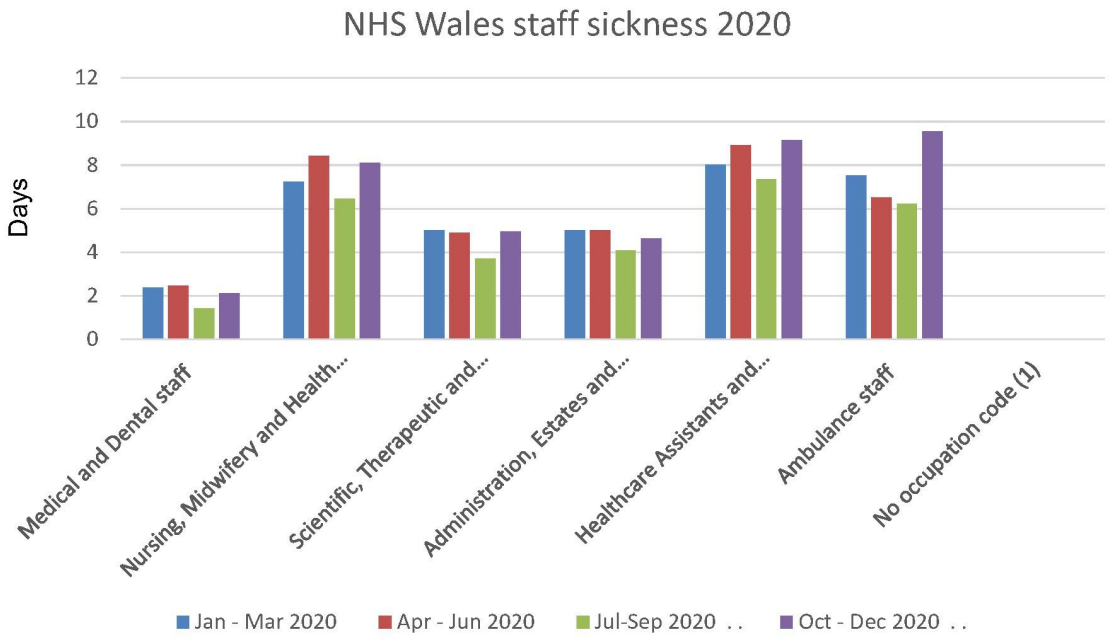


Figure 14 - data for staff sickness 2021

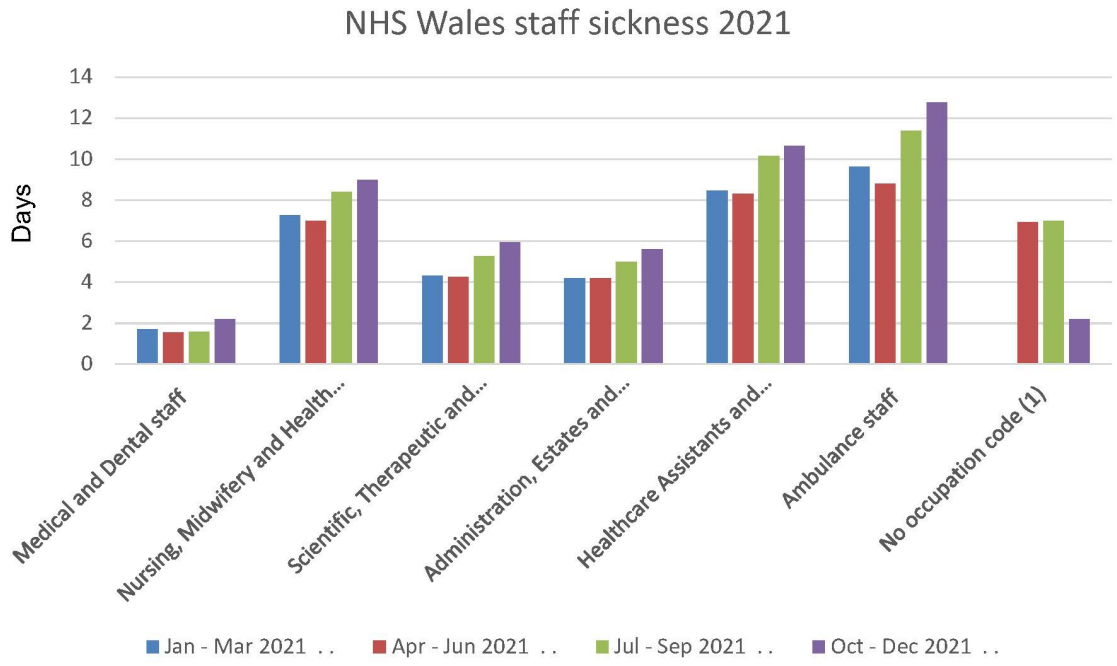
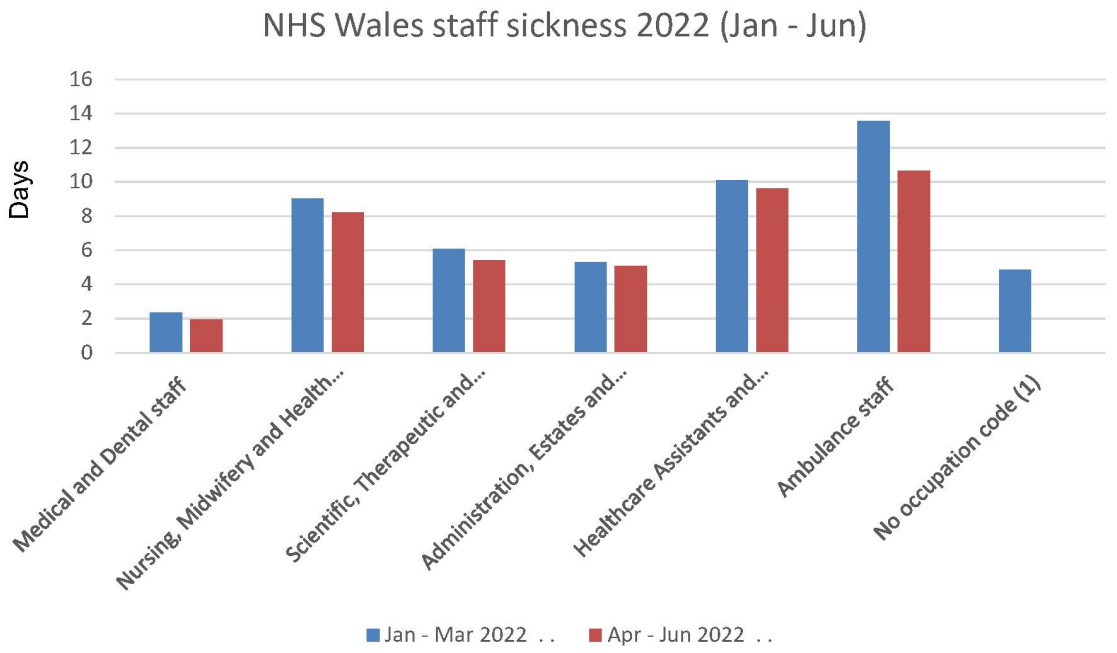


Figure 15 - data for staff sickness 2022



600. NHS Wales organisations were experiencing workforce shortages before the pandemic, as was the case nationally and globally. This impacted on operational and financial performance and continues to represent a significant challenge for health boards and trusts. Welsh Government does not currently hold vacancy data for NHS Wales which is held by individual health boards, with no central collection or publication of this data prior to 31 December 2022.

The impact of staff reduction on care or capacity

601. The Welsh Government did not collect data or undertake analysis on the impact a reduction of staff had on care or capacity. Neither was data collated or analysed on the impact of the availability of testing on face-to-face services.

602. As outlined in my statement in the section on admission to and discharge from hospital, throughout the pandemic healthcare staff were prioritised within the testing capacity available and testing strategies implemented for Wales. It would be for NHS organisations, as the employers and the bodies responsible for delivering services, to consider the impact staff reductions or availability of testing had on their services.

603. It is difficult to carve out and assess if staff absences or the availability of testing caused a reduction in available healthcare staff as other factors need to be considered including other infection and prevention measures in place and being adopted. In November 2022 and again in February 2023 TAG produced a Science Evidence Advice report on Winter planning – NHS Wales Staff absences. A copy of this is exhibited in **AGM3WGO01/234 - INQ000227386** and in **AGM3WGO01/235 - INQ000228587**[83]**.** The purpose of these reports were to help inform workforce plans for winter 2022-23 by estimating NHS Wales staff absences based on historical absences and winter modelling scenarios. It aimed to identify what the likely impact on staff absence in the NHS and other public services. So this it considered the impact of projected hospital occupancies on the NHS staff absence Covid-19 estimation and for the impact on social care staff. This helped to consider the impact of the whole system, not just health care impacts.

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

604. This report indicated that while the aggregated number of sick days taken has increased, so had the total number of staff employed (the average number of sick days per employee has remained consistent over the five years). Anxiety and stress had consistently been the leading sickness absence reason and had also been increasing year on year for the past five years. Covid-19 was been included within the categories 'chest & respiratory problems' and 'infectious diseases', which both saw significant increases to the period financial year 2020/2021. Absence due to 'chest & respiratory problems' decreased by 12% between the periods 2020/21 to 2021/22 whereas absence due to 'infectious diseases' increased by 31% between those periods.

Increasing NHS staffing levels in Wales

605. The Welsh Government agreed funding in March 2020 to support the deployment of nurse, midwife, medical, paramedical, Allied Health Professionals and healthcare scientist students. Funding was also provided to cover the costs of re-employing former staff who had recently left or retired. A copy of the advice provided to the Minister for Health and Social Services for agreement is exhibited in **AGM3WGO01/236 - INQ000226982.**

606. Significant additional workforce capacity was provided by existing staff, working overtime, bank or agency. Their efforts were tremendous and we are grateful for their hard work. The Welsh Government also engaged with the UK healthcare professional regulators who introduced emergency changes to education standards to enable the deployment of healthcare students, and also introduced emergency registers to support the response to Covid. A statement was made by the CMO(W), CNO(W) and Director of Social Services and Integration, Albert Heaney encouraging health and care workers to return. A copy of this statement is exhibited in **AGM3WGO01/237 - INQ000300044.**

607. The Welsh Government website housed a landing page to its website which provided information about how the different professions could register to re-join the NHS. Once temporary emergency registrants were identified by the UK healthcare professional regulators and a list of volunteers produced this was passed to NWSSP who were responsible for contacting the volunteers direct.

608. In January 2022 NWSSP, in response to a request from the Minister for Health and Social Services provided a paper on 'How NHS in Wales is coping with staff shortages this winter'. This paper noted that the NHS in Wales had generated a 52% increase in FTE vacancy activity (i.e. there were 52% more vacant FTE posts) compared with pre-pandemic years November 2018 to November 2021. A copy of this report is exhibited in **AGM3WGO01/238- INQ000227430.**

NHS surcharge for non-UK healthcare staff

609. Immigration and the immigration health surcharge are reserved matters for the UK Government. The Welsh Government was not involved in the decisions in relation to the NHS surcharge for non-UK healthcare staff, however welcomed the UK Government decision and would have raised the continued imposition of the charge. Wales has a long history and proud tradition of welcoming immigrants. It is not clear what impact the removal of the surcharge had. We celebrate the fact that citizens from across the world have come to our country as colleagues, friends and family for many years and make up a significant and vital part of our health and care workforce.

Additional support to healthcare staff

610. As outlined above the promotion of the welfare and wellbeing of our health and care staff was a key priority.

611. Once schools were advised to close the Deputy Minister for Health and Social Services issued a statement on the 20 March 2020 with the Minister for Education, Kirsty Williams to confirm that if a child's parent is critical to the Covid-19 response, then provision in an educational or childcare setting would be available for them. Shortly after on the 6 April 2020 a written statement was issued by the Deputy Minister for Health and Social Services regarding the suspension of the usual childcare offer for Wales for three months from 1 April 2020 to focus resources on supporting the childcare needs of critical workers and confirming the provision of free childcare for pre-school age children of critical workers and children who are considered vulnerable.

612. The Health and Wellbeing Sub-group of the Workforce Deployment and Wellbeing Response Group (Workforce Cell) which was part of the Health and Social Services

Group Planning and Response Group met throughout was established on the 14 April 2020 and took the lead on health and wellbeing. A copy of this groups Terms of Reference is exhibited in **AGM3WGO01/239-INQ000222839.** This group was made up of individuals from NHS Wales, trade unions and the Welsh Government and was another example of collaboration across organisations. This group was stood down in June 2020 and the sub-group's Transition Plan, as exhibited in **AGM3WGO01/240-INQ000227420** provides a good summary of the groups aims and how its work would continue as part of business as usual programmes.

613. Emma Coles also attended the regular meetings on testing and PPE to ensure that information was fed back to the trade unions as soon as possible and any issues brought back to the testing and PPE groups to consider.

614. A Joint Statement on industrial relations and facilities time during the Coronavirus (Covid-19) pandemic was issued by the NHS Wales Welsh Partnership Forum and endorsed by myself on behalf of Welsh Government outlining our gratitude to the workforce for their flexibility and extra-ordinary efforts and recognising that we would work with them as we navigated through the pandemic. A copy of this statement is exhibited in AGM3WGO01/241 - INQ000227412.

615. A Health for Health Professionals scheme, which had been in place for doctors before the pandemic, was extended to 60,000 NHS staff. The service, run by Cardiff University, offered an unprecedented level of support and advice to all healthcare professionals, including doctors, nurses, healthcare professional students, paramedics, therapists, dentists and medical volunteers working in Wales during and post the Covid-19 pandemic. NHS Wales staff were able to call a confidential helpline staffed by healthcare professionals, get access to face-to-face counselling sessions and be provided with guided self-help tools and online resources. The service also supported returning retired staff and healthcare professional students who are volunteering to assist in response to Covid-19. This service continued throughout the pandemic period and is still in place. On 1 April 2022 it was rebranded as 'Canopi' to highlight that it now encompasses both the health and social care sectors.

616. Additionally, a Bespoke Samaritans listening service helpline for health and social care workers was commissioned in August 2020 offering confidential support tailored

for individuals working in health care settings, provided by trained volunteers who would be able to provide support outside of the workplace in recognition of the personal and professional pressures individuals may be under during this unprecedented period. The Welsh Government funding for this service remained in place until August 2022, a total of £170,00 over the two years it was operational, exhibit AGM3WGO01/242-INQ000116690 refers.

617. In terms of monitoring mental health and well-being, this would be undertaken by individual NHS organisations as the employers.

618. In addition to the mental health and well-being support described above, a Welsh Government funded bonus payment for NHS and social care staff was agreed in March 2021. It was estimated the payment would benefit 221,945 people in Wales including 103,600 social care staff, 90,000 NHS Wales staff, 2,345 deployed students and 26,000 primary care staff (including pharmacy, GP, dental and optometry staff). A copy of the advice to the Minister for Health and Social Services on this offer is exhibited in AGM3WGO01/243 - INQ000145062.

619. On the 17 June 2020 the Welsh Ministers made the NHS Business Services Authority (Awdurdod Gwasanaethau Busnes y GIG) Coronavirus Life Assurance Scheme) (Wales) Directions 202084. The scheme rules initially allowed a six-month window linked to the expiry of the Coronavirus Act 202085 to allow claimants time to bring forward outstanding claims in respect of deaths which occurred whilst the scheme was open. This window was extended to 30 September 2023. The scheme enabled families of NHS Wales and social care workers who died in service as a result of Covid-19 to be entitled to financial support with a payment of £60,000. This was in addition to any other existing pension arrangements. The scheme in Wales has received 46 claims since establishment of the scheme in 2020. This consists of 30 claims relating to NHS staff and 16 claims relating to social care staff. Front-line workers were going above and beyond to care for vulnerable patients every day. While no sum of compensation can ever replace a loved one, we wanted to ensure

[84] The directions provide for the NHS Business Services Authority to exercise functions in respect of the National Health Service and Social Care Coronavirus Life Assurance (Wales) Scheme 2020. The NHS Business Services Authority is a Special Health Authority which operates on a Wales and England basis.
[85] Section 45 of the Coronavirus Act 2020.

families had practical support during what must have been an unthinkably difficult time.

Treatment of Covid-19 and non-Covid-19 conditions

620. The pandemic was the most significant public health emergency of our time and placed unprecedented, hitherto unknown demands on the Welsh healthcare system. Many services had to be reduced, and many people were waiting for the care and support they require. In Wales we tried to concentrate our efforts on the 'whole system', putting citizens at the centre and surrounding them with resilient, local primary and community care. Our hospital services were supported to be agile and responsive to the treatment of Covid-19 and management of non-Covid-19 treatments. To inform this section of the statement I have had support from the CMO(W), Frank Atherton, the DCMO(W), Chris Jones and Chief Pharmaceutical Officer, Andrew Evans.

The Health and Social Services Group role in the gathering and dissemination of information within the Welsh healthcare system about the clinical management of Covid-19

621. As already outlined above in this statement the Health and Social Services Group worked closely and in collaboration with the healthcare system throughout the pandemic period taking a key role in acting as a hub for the gathering of information through multi-agency groups such as the Health and Social Services Group Covid-19 Planning and Response Group and its subgroups or via the collation of datasets by KAS working in conjunction with the NHS in Wales.

622. The Health and Social Services Group also participated in the expert advisory group on Covid therapies chaired by Anthony Kessel of NHS England and which prepared the clinical access policies for Covid therapies. At various times this group was referred to as the Four Nations Access and Policy National Expert Group, the Covid-19 Therapeutics Access and Policy group, the Covid-19 Neutralising Monoclonal Antibodies ("nMABs") Access and Policy National Expert Group and the Covid-19 Pre-exposure prophylaxis ("PrEP") Access and Policy National Expert group.

623. The Covid-19 Antivirals and Therapeutics Taskforce was a DHSC-led taskforce which co-ordinated the end-to-end provision of treatments for coronavirus in the UK so that

patients got access to safe and effective treatments as soon as possible. Health and Social Services Group officials worked closely with the Taskforce and clinical advice for the Taskforce came via the Therapeutics Clinical Review Panel which Dr James Coulson, Consultant Physician, Clinical Pharmacologist and Toxicologist and Clinical Director of the All-Wales Therapeutics and Toxicology Centre attended for Wales. This was a helpful source of information on the clinical management of Covid-19.

624. There was also engagement via the CMO(W) and his office with the UK CMOs and the UK senior clinicians as a result of which a number of health circulars were issued with advice about specific clinical access policies for Covid-19 therapies as well as general management of Covid-19. Examples of these include:

    a. Welsh Health Circular on Clinical Assessment of COVID-19 in the Community, dated 4 August 2020 and already exhibited in AGM3WGO01/158-INQ000048607.

    b. CMO Alert - Immediate Actions in response to mink-variant SARS-CoV-2 virus in Denmark, dated 9 November 2020 and exhibited in **AGM3WGO01/244 - INQ000048615.**

    c. CMO Alert - Immediate Actions in response to SARS-CoV-2 virus new variants of concern, dated 27 January 2021 and exhibited in **AGM3WGO01/245 - INQ000048627.**

    d. CMO Alert - Covid-19 Therapeutic Alert - Casirivimab and imdevimab for patients hospitalised due to COVID-19 dated 20 September 2021 and exhibited in **AGM3WGO01/246 - INQ000048669.**

625. The Health and Social Services Group had a role in the commissioning of the development of national guidance for the management of Covid-19 in a hospital setting and its communication to NHS senior leaders. A list of all guidance issued by or commissioned by the Welsh Government has been exhibited in AGM3WGO01/35-INQ000227428 and provided in Annex 2 to this statement for ease of reference.

626. The Health and Social Services Group also commissioned the development of the Covid-19 therapeutics hub for Wales as a single source of information on Covid-19

therapies and related matters. This hub was available on the All Wales Therapeutics and Toxicology Centre website hosted by NHS Wales. The hub was designed to aid clinicians in the appropriate use of medicines during the pandemic with key resources provided for information. The site is however available to the public.

627. As outlined earlier in this statement, an Acute Secondary Care Subgroup was established as part of the Health and Social Services Group Covid-19 Planning and Response structure. This subgroup requested that the NHS National Clinical Lead for Respiratory Medicine develop a national Covid-19 treatment guideline for the NHS in Wales. The guideline included treatment criteria and protocols, supported by healthcare professional tutorials from relevant specialists in Wales. As the web-based platform required NHS clinicians to register their details, any updates to the guidance were notified directly to those registered to inform their clinical practice. The guideline was regularly updated in the early phases of the pandemic as new information emerged. A copy of the letter to local health boards outlining the guideline is exhibited in **AGM3WGO01/247 - INQ000352990.** The Welsh Government does not hold a copy of the guideline. As a result, it cannot be exhibited and cannot be compared to the NICE guidelines in place at the time. This guidance was an online interactive platform hosted by the Institute of Clinical Science and Technology. A copy of the NHS Wales Covid-19 Secondary Care Guideline implementation report is exhibited in **AGM3WGO01/248 - INQ000353153**. This includes five implementation reports published on 7 April 202, 10 April 2020, 24 April 2020, 21 May 2020 and 13 August 2020. The implementation reports provided data on the number of healthcare practitioners registered with the guideline platform, broken down by hospital and type of practitioner. Healthcare staff registered on the platform received the latest clinical information for COVID-19 management in hospitals across Wales and had access to education library with 130+ videos about the management of Covid-19 in hospitals. The 13 August 2020 update noted that there had been a lower registration uptake among nurses (due to factors including lower levels of decision-making and awareness of the guideline and more limited email access to sign up) and reported changes implanted to address this, including facilitating greater access and making clearer that registration was also for nursing staff. It also reported that user feedback had been positive with an overall rating of 4.1 / 5 for the guideline and over 80% of respondents wishing for email updates to continue.

Do Not Attempt Cardio-pulmonary Resuscitation ("DNACPR")

628. Wales has its own clinical policy for DNACPR entitled *'Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales'.* The All-Wales policy for adults was launched in February 2015 and was revised and updated in 2017 and again in 2020. The Advance Future Care Planning ("AFCP") Strategic Group reviews and updates this policy every two years, most recently in April 2022.

629. The policy in place at the start of the pandemic was the 2017 version and exhibited in **AGM3WGO01/249 – INQ000227411.** The policy in place between 2020 and 2022 is exhibited in **AGM3WGO01/250- INQ000283301[86].** The core principles underlying the guidance remains the same but the updated policy included additional resources for patients and their loved ones considering DNACPR and *additional* detail in relation to the All-Wales DNACPR form, how DNACPR discussions should be conducted, who should have those discussions, principles from relevant legal decisions, the requirements and responsibilities of the senior responsible clinician with oversight, and organ donation.

630. The AFCP Strategic Group was established to sit under the NHS Wales End of *Life* Care Board and the DCMO(W). Its purpose is to provide clear leadership and strategic direction for all aspects of Advance Future Care Planning.

631. On the 24 March 2020 Dr Mark Taubert. Clinical Director Palliative Medicine, Velindre University NHS Trust and Chair of the AFCP Strategic Group, contacted the Deputy Chief Medical Officer proposing a Covid-19 update was necessary given that patients who develop Covid-19 deteriorate very quickly and many were likely to not have had discussions about CPR, and which treatments they would and would not want. The Deputy Chief Medical Officer agreed to this course of action and the proposed wording which would be discussed with the AFCO Strategic Group. On the 28 March 2020 Dr Mark Taubert and the Clinical Lead of the End of Life Care Implementation Board wrote out to all Medical Directors, Nursing Directors and WAST to confirm that the all Wales DNACPR policy was being reviewed however, recognising significant concerns

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

about acute situations that arise in Covid-19 where no prior DNACPR or advanced future care plan exists, an emergency update was issued by letter. A copy of this letter is exhibited **AGM3WGO01/251-INQ000226990** and this was shared with the DCMO(W) who agreed the wording before the letter was issued. The key passages of the emergency update to the policy provided:

> *"[T]he COVID-19 pandemic presents exceptional circumstances. The difficulty foreseeing a patient's illness and the risk of sudden deterioration mean that for some people it will not have been possible to get a decision discussed and signed off by a clinician physically at a patient's bedside, before their heart/breathing stops, even if the patient has previously expressed that they would refuse any future CPR. As regulators, including the Nursing and Midwifery Council have acknowledged, exceptional circumstances can mean that the usual rules and practices do not work. During the pandemic it may not be possible to discuss decisions and explore views with a patient. Delirium is common in this disease. It may not have been possible to consult family members/proxy (because of isolation and, in times of crisis, extreme pressure of work) as would normally be expected, but attempts to do so should be timed, dated and annotated. It is accepted that even if these things are not possible, CPR should not be done if it would not work, particularly given the harm it would cause.*
>
> *For patients with severe COVID-19 infection with no treatment options to reverse the disease, or who are known not to want escalation, CPR offers no benefit. In the exceptional circumstances of the current pandemic, clinicians of all professions may try to secure a doctor's decision not to attempt CPR. But we must recognise that this may not be possible.* ***Such clinicians, at the coalface of clinical decision making, should not perform CPR that will not work, and that will cause harm to the patient, resuscitators and bystanders, even if no DNACPR decision has been recorded in advance. They should be supported in deciding not to do so. Such a decision should be rapidly discussed with fellow attendees at the scene of an acute deterioration where there is no DNACPR or ACP in place, agreed and recorded very clearly in contemporaneous notes.*** *An informed and balanced decision to withhold CPR, as has been made abundantly clear in our All Wales DNACPR Policy, does not*

preclude the individual from other forms of treatment if they are needed, or from maximum comfort measures and dedicated care that places dignity as a top priority, and these should be continued in all circumstances." [emphasis in original]

632. Understandably, those working on the frontline in the healthcare system were concerned about decision making around DNACPR particularly in challenging situations on the frontline. A Ministerial Briefing dated the 9 April 2020 on palliative and end of life care, a copy of which is exhibited in **AGM3WGO01/252-INQ000361494** provides a summary of the initial steps taken in Wales and the policy at the time:

    a. The National Clinical Lead for End of Life Care had produced guidance for people with Covid-19 on assessment, care, symptom control and communication around preferences and needs.

    b. The All Wales Covid-19 Secondary Care Management Guideline had been produced to complement the existing guidance on care in the last days of life.

    c. The Welsh Government was working to ensure the adequate and timely supply of medications needed for symptom control and to support hospices.

    d. Wales had clear DNACPR guidance (referred to above).

    e. A range of actions were taken to support people caring for someone dying of a Covid-19 infection, including guidance produced by Baroness Finlay and the Bevan Commission, and training and support for lay carers to provide symptom control medications at home.

    f. The Welsh Government was working with bereavement providers to put in place the capacity for additional support for those at particular risk of complex grief.

633. A new Covid-19 Moral and Ethical Advisory Group Wales ("CMEAG-Wales") was convened to consider and advise the CMO(W) and ministers on moral and ethical

issues in the collective response to the pandemic across public services in Wales. The advisory group developed a framework of values and principles for healthcare delivery in Wales which was sent out to all health board Chief Executives, Medical Directors, Directors of Nursing and Directors of Therapies and Healthcare Scientists on the 12 April 2020. A copy of this letter and the framework is exhibited in **AGM3WGO01/253-INQ000300105.** The framework describes equal concern and respect as the core value to inform planning and decision-making in health care delivery. This means that everyone matters equally, the interests of each person are the concern of all of us and of our society, and the harm that might be suffered by everyone person matters. The framework also defines a number of further principles which it says underpin the ethical delivery of health care: respect, minimising the overall harm from the pandemic, fairness, working together, reciprocity, keeping things in proportion, flexibility, and good decision-making.

634. On the 17 April 2020, the CMO(W) and CNO(W) issued a joint letter to all health boards, to ensure there is clarity around ethical decision making for people with any protected characteristic under the Equality Act 2010, including age, vulnerability, physical or learning disability, autism, other life-long illnesses or conditions such as cerebral palsy, enduring mental health conditions or substance misuse problems. A copy of this letter is exhibited in **AGM3WGO01/254-INQ000300106**. The letter made it clear that age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes. It emphasised that decisions should be made on an individual and consultative basis with people. It made it clear that it is unacceptable for advance care plans, with or without DNACPR form completion to be applied to groups of people of any description.

635. A further joint letter from the CMO(W) and the CNO(W) reiterating this position was issued in March 2021. A copy of this letter is exhibited in **AGM3WGO01/255 - INQ000227370.**

636. Care Inspectorate Wales and Healthcare Inspectorate Wales also issued a joint statement in April 2020 on advance care planning, endorsing the approach to ethical decision making for those with any protected characteristic under the Equality Act 2010, set out in the letter, issued by the Chief Medical Officer and Chief Nursing

Officer for Wales. A copy of this letter is exhibited in **AGM3WGO01/256 - INQ000227432.**

637. The Welsh Government were aware of the CQC review that was commissioned in October 2020 and the subsequent report published in March 2021. The CQC oversees NHS England services and does not undertake any reviews in Wales, so the recommendations from its pandemic report cover the very diverse services and trusts in England. There is, I understand, no single DNACPR policy in England but different policies within different trusts, so a comparison between the Welsh and English policies cannot easily be made.

638. The Welsh DNACPR policy referred to at paragraph 582 entitled 'Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales' place between 2020 and 2022 (as previously exhibited at AGM3WGO01/251 - INQ000227414) took into account the joint statement issued by the BMA, Resuscitation Council (UK), and RCN's entitled: "Decisions Relating to Cardiopulmonary Resuscitation". This guidance in particular was referenced in how to deal with emerging situations where there is no DNACPR form or Advance and Future Care Plan noting that the joint statement noted that "There will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded. Also, there will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies."

639. Whilst the CQC does not make recommendations for Wales, the outcome of the review in England was incorporated into discussions within national groups such as the NHS Wales Palliative & End of Life Care Programme Board. In Wales there is a 2-yearly review of the DNACPR policy which was undertaken in 2020 and 2022. The BMA Ethics committee was drafted into a wider stakeholder event, to ensure any subsequent policy versions had up to date information. Since before the pandemic,

the DNACPR policy in Wales had fundamental principles enshrined on non-discrimination.

640. Several reviews have now taken place of DNACPR practices in Wales, focusing on adherence of clinicians and health boards to the All-Wales policy. This has included an All Wales Thematic Review on DNACPR undertaken by the Mortality Review Working Group, which looked into each health board's practices and principles with regard to DNACPR, and collated examples of practice. This review led to recommendations to a range of stakeholders, including health boards and Welsh Government. Furthermore, Health Inspectorate Wales have made DNACPR inspections a key part of their inspection processes, and have undertaken a Wales-wide DNACPR review, which is due to be published in 2024.

Clinical trials and research into the treatment of Covid-19

641. Wales participated in many of the clinical trials and recruited over 60,000 participants into Covid- 19 related studies. The CMO(W), on behalf of the UK CMOs, wrote to NHS Wales on the 6 April 2020 encouraging the enrolment of Covid-19 patients in three national priority clinical trials. The letter noted that the trials were being run as simply as possible to reduce the burden on the NHS and highlighted their essential nature to the future treatment of patients in the UK and globally. While noting that prescribing decisions were for individual clinicians, the letter strongly discouraged as a wasted opportunity the use of off-licence treatments outside of a trial, where participation in a trial was possible. A copy of this letter is exhibited in **AGM3WGO01/257-INQ000048586.** A further letter on the national clinical trials, again encouraging participation, was sent on the 6 May 2020, a copy of this letter is exhibited in **AGM3WGO01/258-INQ000048596**.

642. NHS organisations came together with national programme leadership via Health and Care Research Wales (which is funded by the Welsh Government) and set up and delivered Covid-19 studies efficiently and at pace, with patient access to research across all areas of Wales. Specific studies were prioritised through a UK process (badged urgent public health ("UPH")) which meant it was clear what should be prioritised locally and proactively facilitated. Wales also participated in the set up and delivery of the Covid-19 Vaccine Research Register, set up to enable individuals in

Wales and across the UK register their interest in participating in vaccine studies for Covid-19. Access to research opportunities varied from attending mass vaccination centres to taking antiviral medication at home. This was facilitated by the 'One Wales' collaborative approach, across all seven local health boards in Wales, coordinated by Velindre University NHS Trust.

643. The Secure Anonymised Information Linkage ("SAIL") Databank, based at Swansea University, provided the Welsh Government's data analysis using anonymised health data. The SAIL Databank is a Wales-wide research resource focused on improving health, well-being and services. Its databank of anonymised data about the population of Wales is world recognised. The SAIL Databank receives core funding from the Welsh Government's Health and Care Research Wales but is independent from the Welsh Government.

644. The range of anonymised, person-based datasets held in SAIL Databank, subject to safeguards and approvals, could be anonymously linked together to address important research questions. SAIL was certified based on the leading international standard focused on information security (by the International Organization for Standardisation (known as ISO 27001)) and accredited by the UK Statistics Authority. It played a key role in supporting data-linkage research that examined the impact of Covid-19 on society and NHS as well as supporting Covid-19 research, securing significant amounts of funding from SAGE National Core Studies programme to support delivery of Covid-19 Research. The Welsh Government does not hold information on the specific clinical trials and research which accessed the SAIL databank.

Maintaining essential services and non-Covid-19 treatment during the pandemic period

645. I have been asked to describe the steps taken by the Welsh Government to monitor and mitigate the impact of the pandemic on the quality of healthcare for conditions other than Covid-19.

646. We followed the advice from the World Health Organisation and professional bodies on the provision of essential services. Clinical colleagues sought to prioritise the care and support of those most in need, minimising the harm from both Covid-19 and non-

Covid-19 conditions, in line with the ethos of the NHS and the published guidance, described below. There were times when we were concerned that fewer people than we expected were accessing emergency or essential services and, as outlined below in respect of the impact of the 'stay at home' messaging, we did seek to encourage the public to access services when needed.

647. The Essential Services Group ("ESG") sat under the Health and Social Services Group Covid-19 Planning and Response Group, which is summarised above. A position statement prepared by the Group in June 2020 and exhibited in a copy of this document is exhibited in **AGM3WGO01/259 - INQ000227195** provides an outline of its work and priorities. The position statement noted the ESG's key deliverables to date, including its review of WHO guidance on maintaining essential health services during an outbreak and the development, approval, production and dissemination of such guidance for Wales. It identified issues to be addressed, such as inequitable services provision across Wales as a result of local variation, the need for consistency of approach as well as regional solutions, and the need to build patient confidence and understanding of how to access services. The position statement also set out the ESG's current workstreams: a comparative review of Welsh guidance with revised WHO and NHS England guidance, development and refinement of the Essential Services national assurance framework, supporting the NHS to identify opportunities for mutual aid and to develop regional responses, a range of national media campaigns, and work to facilitate a consistent national approach where appropriate.

648. Any guidance in relation to the maintenance of essential services was cleared by experts in this group prior to being published on the NHS Wales website. The Coronavirus: ethical values and principles for healthcare delivery framework was applied in determining those services that should be deemed essential as well as the guidance issued by the World Health Organisation.

649. Guidance on Maintaining Essential Health Services during the COVID 19 Pandemic – summary of services deemed essential was issued on 4 May 2020, exhibited in **AGM3WGO01/260-INQ000182443** and updated on 12 June 2020, exhibited in **AGM3WGO01/261- INQ000182461** which were required to be read respectively with

the Quarters 1 and 2 NHS Wales Operating Framework as exhibited earlier in this statement at paragraph 202.

650. The Essential Services guidance set out the following services:

1. Primary care (which included essential, additional and a limited range of enhanced services that fulfil the World Health Organisation high priority categories)
2. General Medical Services plus the following enhanced services: childhood immunisation, pertussis immunisation for pregnant and rubella for post-natal women and oral anticoagulation.
3. Community pharmacy services
4. Urgent dental care including severe swelling, trauma, and bleeding.
5. Optrometry services
6. Community nursing and Allied Health Professionals services
7. Emergency ambulance services
8. Urgent surgery, including access to urgent diagnostic and related rehabilitation.
9. Urgent cancer treatments including access to urgent diagnostic and related rehabilitation
10. Life saving medical services, including access to urgent diagnostic and related rehabilitation
11. Life saving or life impacting paediatric services
12. Termination of pregnancy
13. Other infectious conditions
14. Maternity services

15. Neonatal services

16. Safeguarding services – all ages

17. Mental health, NHS learning disability services and substance misuse

18. Urgent supply of medications

19. Renal care

20. Blood and transplant services

21. Palliative and end of life care

22. Paediatric specialist services (added quarter 2)

23. Paediatric diabetes (added quarter 2)

24. Cardiac and Stroke Services (added quarter 2)

25. Hip fracture surgery (added quarter 2).

651. The guidance signposted further relevant Welsh Government and other relevant guidance in respect of individual areas. It also detailed five prioritisation levels for surgery and linked to *Clinical guide to surgical prioritisation during the coronavirus pandemic* guidance, dated 11 April 2020 and exhibited in **AGM3WGO01/262 - INQ000226460**[87], which categorised procedures from different surgical specialities into the five priority levels. The five priority levels are:

v. Priority Level 1a Emergency – operation needed within 24 hours.

vi. Priority level 1b Urgent – operation needed with 72 hours.

vii. Priority level 2 Surgery that can be deferred for up to 4 weeks.

viii. Priority level 3 Surgery that can be delayed for up to 3 months.

[87] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000399073]

ix. Priority level 4 Surgery that can be delayed for more than 3 months.

652. The All-Wales Therapeutics and Toxicology Centre ("AWTTC") responded to the challenges of the COVID-19 pandemic, re-organising work priorities and adapting to meet the needs of NHS Wales and Welsh Government. A brief report on AWTTC's work since the introduction of lockdown is exhibited in **AGM3WGO01/263 - INQ000227391**. This work included:

653. The creation of the Covid-19 therapeutics information hub, a central repository of resources for prescribers on the use of medicines during the pandemic, reviewed daily.

a. Assisting with the monitoring of critical medicines stocks to support procurement and allocation decisions.

b. The implementation of a process which, in accordance with NICE guidance, allowed for the timely approval in Wales of interim treatment regimens which had been clinically assessed and endorsed by NHS England, enabling clinicians to access the same medicines as colleagues in England.

c. Coordination of the implementation of the end-of-life medicines service, called 'Just in Time', which provided emergency medical packs to patients within a two-hour window.

d. The provision of advice on pharmacological management of certain conditions during the pandemic. Guidance on the management of non-COVID conditions during the pandemic (when contact with the health service was limited) was also issued.

654. The Medicines Shortage Advisory Group Wales ("MSAG"), during the pandemic implemented active stock monitoring of critical medicines to manage shortages and established a Covid-19 medicines stockpile. This group was established in February 2019 by the Welsh Government to further support the management of medicines shortages in Wales. Advice was issued to NHS on managing demand for essential medicines during the pandemic, a copy of which is exhibited in **AGM3WGO01/264-INQ000227198.**

655. Throughout the pandemic period we were conscious of the impact of the pandemic on the availability of treatment for non-Covid-19 conditions, particularly whilst the response and contingency arrangements for Covid-19 were at the highest escalation. The Operational Planning Frameworks that were issued for each quarter, as outlined in paragraph 202 in this statement, out the requirements for NHS Wales and committed to a phased and iterative return to more routine healthcare activities. These frameworks were aligned with the 'four harms' which included harm from reduction in non-Covid-19 activity.

Impact of the "stay at home, protect the NHS, save lives"

656. Given the similarity of the messaging and restrictions in place across the four nations of the UK at the start of the pandemic period, a four-nations approach was maintained, and all nations adopted the "*Stay Home, Protect the NHS, Save Lives*" campaign messaging. This was regularly reviewed through a four-nations Covid marketing group established in February 2020 which HSS communications colleagues attended, and through a group attended by the Directors of Communications for each of the four nations.

657. In April 2020, whilst the "*Stay Home, Protect the NHS, Saves Lives*" messaging remained consistent across the four nations, the Welsh Government and Welsh Ministers chose not to adopt, for use in Wales, a new style of campaign materials produced by the UK Government. This was because the new campaign used an urgent / emergency style and tone which was not consistent with that set by Welsh Ministers in press conferences and in government communications, where the efforts of the Welsh population were recognised and thanked.

658. While the "Stay Home" campaign was lead by the Welsh Government we relied on amplification by local partners such as NHS Wales and local authorities to highlight the key messages to the public about how to safely access to NHS Wales services. These key messages were adapted and built on by individual organisations as part of the quarterly operational planning framework.

659. The first phase of this national campaign covered six key pillars - Emergency Departments, GP surgeries, Maternity Services, Child Health (Emergency

Departments, Vaccinations and Diabetes), Mental Health and Cancer Services. The campaign included social media and digital, press adverts and radio. The aim was to communicate to the public that, while there were changes to some services, the NHS was there for those in need of urgent care. It aimed to encourage people to seek help for illnesses and conditions not related to Covid-19, for themselves or their children, and not leave it too late. A set of general messages was developed, as well as condition-specific messages covering the key pillars described above. There was a particular focus on a key pillar each week. Activities included a combination of Ministerial mention in a daily session, a press release highlighting the issues, video content and stakeholder promotion. In addition to the planned campaign NHS bodies would also be asked directly to provide comment to local news outlets or Public Health Wales officials would be asked to provide information for press articles and news stories. The national campaign did not, to my knowledge, include specific messaging relating to heart disease, hip replacements or elective orthopaedic surgery, though local health boards may have carried out their own communications campaigns in relation to these areas.

660. Following an audit of Covid-19 patient pathways conducted in Aneurin Bevan University Health Board, the CMO(W) issued a Welsh Health Circular on 4 August 2020 to all general practices in Wales highlighting concern that patients may avoid presenting with severe symptoms of Covid-19. It encouraged general practice to assess patients whose symptoms were not improving. A copy of the circular is exhibited above in AGM3WGO01/158-INQ000048607.

661. In parallel, national messaging was adjusted to include symptoms that should prompt help seeking behaviour. A Written Statement and Press Notice were issued on 4 August 2020 describing when to seek medical assistance. A copy of the statement is exhibited in **AGM3WGO01/265 - INQ000227421.**

662. As the public face of NHS Wales, I committed to weekly press conferences when required in the initial phases of the pandemic from March to September 2020, later switching to press updates as required often at times when public concerns were higher or the NHS in Wales was under visible pressure. I remained mindful of the need for clear and transparent communications, and an honest conversation with the

population of Wales to build public confidence in NHS Wales planning and preparation and an understanding about the pressures faced by NHS Wales at this time – reinforcing the message of "Stay Home; protect the NHS; and save lives". These public communications enabled me to convey the progress, as well as the challenges, across the range of issues being addressed by NHS Wales. I hope that this helped to instil some trust and confidence in NHS Wales and the way in which it exceptionally prepared.

Diagnostic screening, care and treatment and targets for cancer care during the pandemic period

663. The cancer waiting time target continued during the pandemic, but public reporting ceased for a period of time. The Welsh Government issued guidance to the NHS on 1 April 2020 on the agreement to reduce the burden of reporting, in this it noted the importance of continuing cancer delivery but agreed performance management of the target would be suspended initially. A copy of this guidance is exhibited in **AGM3WGO01/266 - INQ000227380.**

664. To support cancer service delivery, Welsh Government officials worked closely with the All Wales Cancer Network to consider the likely impact of the pandemic on cancer care. National guidance was developed for cancer services to guide prioritisation and access to treatment in April 2020, and revised in June 2020, as exhibited in **AGM3WGO01/267 - INQ000353461.** This recommended that the reinstatement of cancer services impacted by Covid-19 required organisations to have systems in place to ensure safety in light of the ongoing risk from Covid, designated hospital sites and/or zones separating acute and elective services, major service redesign to create sufficient capacity for the projected demand, preparation and support for patients prior to entering facilities, the reduction of staff risk through rotas and/or testing, and adaptation in light of guidance on nosocomial transmission and changing levels of Covid-19 infection risk. It emphasised that essential services should be maintained, and activity should increase to deal with the backlog of deferred patients and the expected rise on referrals, and that previous prioritisation categories stratified based on clinical benefit and risk, together with clinically lead individual decisions, should still be used.

665. The quarterly national coordination meeting for NHS cancer services (the Wales Cancer Network Board, which includes representation by the Welsh Government) was suspended and replaced by a more frequent and smaller coordination meeting to monitor and respond to the impact on services during the pandemic period. In support of this, a monthly meeting (subsequently bimonthly) of health board cancer operational managers (including observers from the Welsh Government) was convened to track patient pathway data and service pressures.

666. I wrote out to NHS Wales and issued guidance on the continuation of cancer services to health boards:

667. On 1 April 2020, as exhibited in **AGM3WGO01/268 - INQ000227390**. This letter indicated that officials were working with the Wales Cancer Network to provide a framework of guidelines. In the meantime, I requested that urgent consideration be given to how to ensure emergency and urgent cancer treatment could continue, that appropriate records be kept where referrals or treatment plans departed from normal practice, and that regional solutions be agreed to ensure urgent needs could be met, including the possible use of the independent healthcare sector.

668. A letter on 9 April 2020, as exhibited in **AGM3WGO01/269 - INQ000262353**[88], accompanied by updated guidance on the minimum level of cancer service provision required, exhibited in **AGM3WGO01/270 – INQ000399069**. The guidance emphasised that urgent and emergency cancer tests and treatment should continue recognising that maintaining integrity of cancer services and patient outcomes are important alongside acute COVID-19 care; that there should be adequate safety netting for patients whose pathways are affected; and that plans should be developed to deal with a robust and prolonged recovery phase, thinking boldly and beyond organisational boundaries. It described priority categorisation levels in respect of the different areas of cancer services (surgical patients, systemic anti-cancer treatments, radiation therapy and diagnostics), and outlined a three-phase framework approach:

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

a. Acute phase: peak acute service demand due to COVID-19 (0 - 6/8 weeks): Continue to deliver urgent and emergency cancer services. The exact dates for peak acute service demand varied between health boards but in general this commenced around mid to late March 2020 lasting until end of April or start of May 2020.

b. Recovery phase: emerging from peak demand but ongoing service disruption (6 - 24/36 weeks): Develop a service model that minimises harm from the acute phase and deals with the backlog of cases using the most efficient, effective and evidence-based approach. The recovery phase varied between health boards but in general this commenced end of April or early May 2020 and went up until the autumn /winter period, so mid October to mid December 2020.

c. Reactivation phase: minimal service disruption due to COVID-19 (24 – indefinite weeks): Recommencement of 'regular' cancer services, but adopting lessons learned and new models of care where appropriate from the acute and recovery phases. The reactivation phase started around mid October 2020 but varied between health boards so could have been later depending on the length of the recovery phase.

669. On 5 May 2020, as exhibited in **AGM3WGO01/271 - INQ000227155**. This letter (incorrectly dated 5 April 2020) highlighted my concern about cancer services and the need to urgently review the extent of the impact of the pandemic on cancer treatments. I asked for an update on the eight requested actions in the guidance sent with my previous letter and noted that I had asked the Wales Cancer network to work with health boards and Trusts to advise on local plans and the need for any regional or national solutions.

670. Additionally, the revised NHS planning framework arrangements as outlined earlier in this statement at paragraph 202 included the continuation of cancer services in line with national guidance. I also hosted a summit of senior leaders to discuss cancer services on 8 July 2020.

671. In terms of monitoring and targets for cancer treatment, in June 2020 we wrote out to the NHS to recommence data flow. A copy of this letter is exhibited in

AGM3WGO01/272 - INQ000227173. On the 20 October 2020 we wrote to the NHS to indicate that we would commence the publication of national statistical data. A copy of this letter is exhibited in **AGM3WGO01/273 - INQ000227256.**

672. In November 2020 we published the new cancer data sets for our new cancer measurement the single cancer pathway this indicated a move away from the two cancer targets 62 and 31 day targets to one single cancer target of 62 days. The Data Standards Change Notices ("DSCNs") were approved by the Welsh Information Standards Board ("WISB") and the following standards issued by NWIS to the NHS organisations in Wales:

    a. DSCN 2020 / 24 National Cancer Data Standards for Wales – Site Specific – Sarcoma, as exhibited in **AGM3WGO01/274 - INQ000227434.**

    b. DSCN 2020 / 25 National Cancer Data Standards for Wales – Patient Group Specific – Teenage Young Adult (TYA), exhibited in **AGM3WGO01/275 - INQ000227435.**

    c. DSCN 2020 / 26 National Cancer Data Standards for Wales – Site Specific – Urology, exhibited in **AGM3WGO01/276 - INQ000227433.**

673. WISB is the body established to oversee the Information Standards Assurance process (then called the Information Governance Process). This was previously called the Welsh Information Governance & Standards Board and was established in May 2006 but since 2021 operated under the new name, as the WISB.

Shielding of Vulnerable Individuals and the Clinically and Extremely Vulnerable

674. Early in the pandemic members of the public were identified by health professionals as being clinically vulnerable ("CV") or clinically extremely vulnerable ("CEV") to severe complications of the coronavirus ("Covid-19"). The CEV individuals were identified based on the severity, history and treatment levels of their condition(s) and collated in a list referred to as the "shielding patient list" or "SPL". These individuals were advised by the CMO(W) and via Welsh Government policy and guidance to shield themselves from the risk of transmission by limiting their social contacts.

675. The shielding programme was introduced by the Welsh Government on 16 March 2020 and ended on 31 March 2022. In my role of Director General Health and Social Services I was aware of and updated on the shielding programme but during pandemic period the CMO(W) with support from the DCMO(W) was principally responsible for clinical classification of the CV and CEV which was used to develop the Welsh Government's policy on shielding and the protection of clinically vulnerable persons. Frank Atherton, CMO(W) and Chris Jones, DCMO(W) have therefore provided me with assistance for this section of my statement however this will be an overview of the Welsh Government policy and more detailed information will be provided by the CMO(W) in his own evidence for Module 3.

The Welsh Government's role in the initial development of the shielding policy and guidance for the clinically vulnerable and the clinically extremely vulnerable groups in Wales.

676. As set out at the beginning of my statement, the Welsh Ministers are responsible under the NHS (Wales) Act 2006 for the promotion and provision of a comprehensive health service designed to secure improvement in the prevention, diagnosis and treatment of illness. As such shielding policy in Wales was the responsibility of the Welsh Ministers (served by the Welsh Government Department of Health and Social Services).

677. The health conditions (or age groups) identified in Wales as giving rise to increased susceptibility to Covid-19 were based upon clinical input from the four CMOs and Senior Clinicians from the UK including within NHS Wales.

678. On the 3 March 2020 a joint action plan between the UK Government and devolved Governments in Wales, Scotland and Northern Ireland was published, 'Coronavirus action plan: a guide to what you can expect ("joint action plan") which is exhibited in **AGM3WGO01/277 - INQ000057508**[89]**.** While the joint action plan did not refer to shielding individuals directly, it set out a phased response to the virus and noted *"[s]o far the data we have suggest that the risk of severe disease and death increases*

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

among elderly people and in people with underlying health risk conditions (in the same way as for seasonal flu)".

679. On the 5 March 2020 the Scientific Advisory Group for Emergencies ("SAGE") discussed the need for vulnerable groups to be identified and protected confirming *"there is scientific data to support implementation – roughly 2 weeks later – of social isolation (cocooning) for those over 65 or with underlying medical conditions to delay spread, modify the epidemic peak and reduce mortality rates."*

680. The Chief Scientific Adviser for Health ("CSAH"), Rob Orford attended the meeting on the 5 March 2020. Following this meeting the CMO(W) was provided with a written briefing from Rob Orford outlining the discussion at SAGE, which is provided in exhibit **AGM3WGO01/278 - INQ000227250.** This confirmed that: "Early enactment of social distancing for those over 65 unlikely to delay peak or significantly impact peak height but could reduce 25-35% of deaths and decrease demand for hospital and critical care beds. This group is estimated to contribute up to 5% of cases but 20-35% of deaths".

681. On 16 March 2020 the Welsh Government, in conjunction with the UK Government, issued guidance, advising those who were at increased risk of severe illness from Covid-19 to be particularly stringent in following social distancing measures. This was based on advice from the Scientific Advisory Group for Emergencies agreed on the 10 March 2020 which outlined social distancing measures for the elderly (over 70s) and consideration for vulnerable groups of all ages. A copy of this guidance is exhibited in **AGM3WGO01/279 - INQ000080866.** This group included those who were:

i. aged 70 or older (regardless of medical conditions)

ii. under 70 with an underlying health condition listed below (ie anyone instructed to get a flu jab as an adult each year on medical grounds):

iii. chronic (long-term) mild to moderate respiratory diseases, such as asthma, chronic obstructive pulmonary disease, emphysema or bronchitis

iv. chronic heart disease, such as heart failure

v. chronic kidney disease

vi. chronic liver disease, such as hepatitis

vii. chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis, a learning disability or cerebral palsy

viii. diabetes

ix. a weakened immune system as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets

x. being seriously overweight (a body mass index (BMI) of 40 or above)

xi. those who are pregnant.

682. The advice on the 16 March confirmed that further advice would follow for those with particular clinical conditions which put them at even higher risk of illness from Covid-19.

683. The four national UK CMOs, advised by clinical leaders, agreed the clinical criteria for those who were at even higher risk, the CEV, who would be to be advised to shield. On 17 March 2020, the UK CMOs finalised the interim list of conditions as set out in exhibit **AGM3WGO01/280 - INQ000226948** and requested comments from clinical advisers. Heather Payne, Professional Lead for Maternal and Child Health, advised CMO(W) that she had requested children's conditions to be added to the list and the Chief Nursing Officer's team took forward reviewing principles and guidance for health boards to keep children out of acute settings, if possible, as exhibited in **AGM3WGO01/281 - INQ000226949.** The final agreed list was cleared by the Chief Medical Officers on the 18 March 2020 as exhibited in **AGM3WGO01/282 - INQ000226953:**

i. Solid organ transplant recipients.

ii. People with specific cancers

iii. Severe respiratory conditions, including all cystic fibrosis, severe asthma and severe Chronic Obstructive Pulmonary Disease (COPD)

iv. Rare diseases and inborn errors of metabolism that significantly increase the risk of infection (such as Severe Combined Immunodeficiency (SCID), homozygous sickle cell)

v. People on immunosuppression therapies sufficient to significantly increase risk of infection

vi. Pregnancy with significant congenital heart disease

684. On 22 March 2020 in England, the Secretary of State for Housing, Communities and Local Government announced that those people in England who faced the highest risk of being hospitalised by Covid-19 should shield themselves and stay at home. This marked the start of shielding in England. Government guidance urged people considered CEV to the virus to not leave their homes for 12 weeks and not go out for shopping, travel or leisure.

685. Identification of all CEV individuals in Wales was a significant and complex task. The Welsh Government officials working on this with NHS colleagues did an amazing job pulling together a complex piece of analysis and patient reconciliation which had never been done before and certainly not at the pace at which they did so. The initial criteria for the "at risk" CV group announced on the 16 March could have been processed drawing heavily on the GP register but once the more clinically specific list for the CEV was confirmed by the UK CMOs on the 18 March there were issues with accessing and aligning the data points to create an accurate database of individuals. In England, central bodies such as NHS Digital already had access to a national prescribing database able to support the data runs necessary for the shielding patient list. We did not have an equivalent national prescribing database in Wales at the time so were unable to produce an accurate list as quickly. As I will outline below in more detail, we needed to collate multiple national datasets and match these to prescription data held by the NHS Wales Shared Services Partnership (derived from 2D barcodes included on every prescription generated by patients' registered GP practices) and

patients' NHS numbers. The data was therefore available in Wales but not collated in one place to be easily accessible.

686. The CMO(W) commissioned a collaboration of national bodies in Wales (NWIS, DU, Shared Services and Public Health Wales) to identify those in Welsh population who met the clinical criterial agreed by the UK CMOs. This list was referred to as the Shielded Patient List ("SPL").

687. The identification of patients for inclusion in the SPL involved interrogation and analysis of multiple national datasets collected by NHS Wales. These included:

    a. Patient Episode Database for Wales ("PEDW") namely Admitted Patient Care ("APC")

    b. Prescription Pricing Service ("PPS")

    c. Welsh Demographics Service ("WDS")

    d. Maternity Services Dataset ("MSDS")

    e. Cancer Network Information System Cymru ("CaNISC")

    f. Congenital Anomaly Register & Information Service ("CARIS")

    g. Using searches deployed via Audit+ ("Audit+")

    h. Critical Care Dataset ("CC")

    i. Hospital Pharmacy

    j. Office for National Statistics Daily Death Notifications

    k. Electronic Master Patient Index ("eMPI")

688. The methodology for high risk shielded patient list identification is summarised in exhibit **AGM3WGO01/283 - INQ000395540.**

689. We were aware the other nations would be asking questions as we were, and we were keen to see if they had already mapped out answers. The DHSC helpfully shared its

near final draft of their letter and guidance to vulnerable groups for shielding from the virus. We did experience some issues with getting information from NHS England on the approach they were taking for the broader criteria, for example what encompassed "severe respiratory conditions" as we wanted to ensure alignment across the nations as far as possible.

690. The NHS Delivery Unit undertook an initial assessment of the criteria and confirmed that currently we would only be able to identify a proportion of the patients, approximately 70-80%. Work would be needed to be done to link with prescribing dataset and cancer systems in order to complete the full list (as noted in exhibit **AGM3WGO01/284 -INQ000226954**).

691. I informally advised the Minister for Health and Social Services and the First Minister along with their Special Advisers, by email that these issues would delay, albeit slightly, Wales commencing its shielding programme, my email to ministers is exhibited in **AGM3WGO01/285 - INQ000226955**. Ministers and the WLGA were very keen to get the list finalised but it is important to highlight the technical complexity of this data exercise in Wales. It was, I understand, not just a matter of producing a list of Welsh patients, it was a case of reconciling many different records from hospital admissions and intensive care admissions to GP and prescribing records to produce an accurate record of patients defined by a clinical definition by the UK CMOs. What we were asking individuals on this list to do, and the impact of that request was unprecedented. We had to be confident that the list was as accurate as possible before proceeding.

692. On the 24 March 2020 the Welsh Government announced measures to protect those at highest risk from coronavirus which was supported by guidance for those who are identified as extremely vulnerable to the virus. The announcement confirmed that those at highest risk would be given specific advice about how they can protect themselves, based on their individual medical history and health needs. On the same date 88,000 shielding letters were issued to the 'Phase I' cohort. A copy of this letter is exhibited in **AGM3WGO01/286 - INQ000226987** and it included advice to:

1. Strictly avoid contact with someone who is displaying symptoms of coronavirus (COVID-19). These symptoms include high temperature and/or new and continuous cough.

2. Not to leave their house for at least 12 weeks (up to 15 June 2020) unless it is absolutely vital.

3. That visits from carers or healthcare workers, who would normally come and help with daily needs or social care, would be able to carry on as normal.

4. Not to attend any gatherings. This includes gatherings of friends and families in private spaces, for example family homes, weddings, parties and religious services.

5. Not to go out for shopping, leisure or travel and, food or medication deliveries, should be left at the door to minimise contact.

6. To keep in touch using remote technology such as phone, internet, and social media.

693. On the same date the CMO(W) issued a public health link to NWSSP to forward to all General Practitioners asking that they ensure the message was seen by all practice nurses and non-principals working in their practice. A copy was also provided to all the health boards and NHS trusts (including Public Health Wales) and NHS Direct, the British Medical Association, the Royal Colleges and Community Pharmacy Wales. A copy of this message is exhibited in **AGM3WGO01/287 - INQ000080900.**

694. In April 2020 work started on Phase II of the SPL in Wales. A briefing to the CMO(W) was prepared by the NHSDU outlining the requirements for Phase II used in England and the impact this would have on the number of Welsh individuals who would be included on the SPL. The report, exhibited in **AGM3WGO01/288 - INQ000227084**, explained that the NHS England had expanded its shielded list through changes in the methodology used to identify patients from primary and secondary care who met the relevant criteria. Due to technical differences in the underlying systems for coding patients used in Wales and England, primary care suppliers in Wales could not immediately apply the same methodology in Wales, and an alternative process was

being investigated. The report estimated that if Wales were to follow a similar approach to NHS England's, approximately 13000 patients would immediately be added to the Welsh SPL, with this figure to grow as all aspects of the NHS England methodology became available in Wales.

695. The CMO(W) was asked to confirm whether Wales would align with the position taken in the other nations or diverge. The CMO(W) confirmed that it would be sensible to align our lists with the other UK nations, exhibit **AGM3WGO01/289 - INQ000227088** refers. An informal briefing was submitted to the Minister for Health and Social Services at the CMO(W) request, exhibit **AGM3WGO01/290 - INQ000227090.** This noted that:

a. An estimated 13,000 patients would be added to the Welsh Shielded Patient List as a result of the alignment, taking the number advised to shield in Wales to a minimum of 116,500.

b. GPs would be provided with an updated list of their patients who have been identified centrally and would remain able to identify and add further patients, including English-border GP practices with Welsh resident patients.

c. Secondary Care Clinicians/Specialists would be provided with the updated Welsh Shielded Patient List and would also now be able to identify and add further patients.

d. Local authorities would be alerted directly by the Welsh Government and through the Welsh Local Government Association and provided with the updated Welsh Shielded Patient List. Local authorities would be asked to proactively contact the added patients and the Wales Council for Voluntary Action will also be notified on behalf of the third sector.

e. The major food retailers would be provided with the updated Welsh Shielded Patient List to allow for Phase II patients to be provided with priority delivery slots.

696. A report outlining how the SPL was formulated between March to July 2020 was produced by NHS Wales Informatics Service ("NWIS") a copy of which is provided in **AGM3WGO01/291 - INQ000385360**. I will not reiterate the contents of this report

which provides a good contemporary summary of the initial phases of the work undertaken to identify individuals for the SPL.

697. Subsequent changes to the clinical criteria for the CEV group were made but these were in line with the other three nations and on agreement with the UK CMOs. On the 1 July 2020 the four UK CMOs endorsed the statement within the Royal College of Paediatrics and Child Health ("RCPCH") guidance that they should remove most children from the shielding list but agreeing that no child should be removed from the SPL without a conversation with a clinician. On the 5 August 2021 the 4 UK CMOs agreed that those under 18 should no longer be considered CEV and should be removed from the shielding patient list.

698. While the four UK CMOs made collective decision around the criteria it is important to note that once the four nations began to diverge in relation to the imposition and non-imposition of restrictions, they were of course working in different contexts in terms of what impact adding or removing the requirement to shield for those clinically vulnerable individuals.

A chronological overview of the shielding guidance throughout the pandemic period

699. Initial guidance was issued on the 24 March 2020 on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus. This explained what was meant by extremely vulnerable and the importance of shielding. It strongly advised staying at home at all times and avoiding face to face contact, save for carers and healthcare workers without symptoms, for at least 12 weeks from receipt of a shielding letter. It provided advice on minimising risk including hand-washing and other hygiene measures; arranging for food and medication to be delivered, with the help of family, friends and neighbours if necessary; the use of technology to keep in touch with people, GPs and other essential services; minimising contact with other people in the same household who weren't shielding; writing a list of alternative carers in case a main carer becomes unwell; steps to be taken by informal carers to minimise risk; what to do if symptoms of Covid-19 developed; and advice on maintaining mental wellbeing. A copy of this guidance is provided in **AGM3WGO01/292 - INQ000080896.** An easy read version of this guidance was issued on 1 April 2020, exhibited in **AGM3WGO01/293 - INQ000081032**.

700. This was followed on 3 April 2020 by a letter from the Chief Medical Officer to those on the SPL explaining the support available to them: local authorities had been provided with their contact details to offer support, priority delivery slots were available for online shopping deliveries and free food boxes could be requested where online shopping or other alternatives were not possible. A copy of the letter is exhibited in **AGM3WGO01/294 - INQ000080944**.

701. Also on 3 April 2020, a public health link was sent to GPs providing information about the SPL and the shielding letters. It also gave answers to a number of practical questions such what to do if a patient had received a letter but did not know why or had expected to receive a letter but had not. The letter highlighted GPs' ability to generate shielding letters where they and the patient believed the patient meet the criteria. A copy of the public health link is exhibited in **AGM3WGO01/295 - INQ000048588**.

702. The guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus was updated on the 8 April 2023 to include the information in the Chief Medical Officer's 3 April 2020 letter regarding available support and a link to advice on social distancing. A copy of this guidance is provided in **AGM3WGO01/296- INQ000080982.**

703. Easy read versions of the guidance were published on the 23 April 2020 and was exhibited previously at AGM3WGO01/293 - INQ000081032 and exhibited here at **AGM3WGO01/297 - INQ000081043.**

704. A statement was made by the Minister for Health and Social Services on the 5 May 2020 confirming there had been a refinement of the medical criteria for shielding in line with the other three nations. Updated guidance was published and is exhibited at **AGM3WGO01/298 - INQ000081108.** This replaced 'People who are pregnant and children up to the age of 18 with significant heart disease, congenital or acquired' in the list of groups to shield with 'pregnant women with significant heart disease, congenital or acquired' and 'children up to the age of 18 with significant heart disease, congenital or acquired'. The previous advice to stay at home and avoid face to face contact 'for at least 12 weeks from receipt of the letter' was updated to 'until at least 15 June 2020'. The CMO(W) sent letters to further high-risk patients advising them to

shield. As a result, approximately 21,000 patients were added to the SPL (taking the number advised to shield in Wales to approximately 121,000).

705. On the 1 June 2020 the Minister for Health and Social Services announced two changes for people who are shielding based on advice from the CMO(W). Firstly, they could exercise outdoors an unlimited number of times a day. Secondly, they could meet with another household outside on the same terms as the everyone else in Wales.

706. On the 2 June 2020 Minister for Health and Social Services agreed to the CMO(W) proposal to continue shielding until 16 August 2020, a copy of the advice to the Minister for Health and Social Services is exhibited at **AGM3WGO01/299 - INQ000144908**. An announcement confirming this was issued on the 4 June 2020 a copy of which is exhibited at **AGM3WGO01/300 - INQ000227166**. Guidance was updated on the 8 June 2020, a copy of which is exhibited at **AGM3WGO01/301- INQ000081191** and this guidance reflected the advice of the CMO(W) for clear messaging to those on the list to ensure when exercising or mixing with other household to act with caution.

707. On the 22 June 2020 after the UK Government updated its advice to people who are shielding in England, the DCMO(W) issued a statement to say that shielding advice has not changed in Wales, where it is in place until 16 August, a copy of this statement is exhibited at **AGM3WGO01/302 - INQ000227186.**

708. The Welsh Government announced that two households in Wales could form what is termed an "extended household" from 6 July, enabling them to meet up indoors and stay overnight; the extended household measure also included people who are shielding and the CMO(W) issued advice on this, a copy of which is exhibited at **AGM3WGO01/303 -INQ000227201.**

709. On the 31 July 2020 Shielding was paused in the other nations but in Wales this continued until the 16 August 2020. This decision to continue Shielding in Wales was made by the Minister for Health and Social Services.

710. New guidance was issued on the 16 August 2020 at the point at which shielding was paused in Wales. A copy of this guidance is exhibited at **AGM3WGO01/304 - INQ000081384.**

711. Early October 2020, as levels of Covid-19 were increasing across most areas of Wales and other parts of the UK, the 4 UK CMOs advised that shielding should not be reintroduced, however advice to this group on how to keep safe could be issued to support those on the SPL to manage their own risk.

712. On the 22 October 2020 the CMO(W) wrote to those who were CEV and were previously shielding ahead of the firebreak period being introduced in Wales. While there was no requirement for shielding to re-start the letter contained the latest advice to people on how to take extra care and best protect themselves. This included reducing contact with family and friends from other households even after the firebreak period, handwashing and surface cleaning, social distancing, shopping online (with priority supermarket delivery slots still available) or at quieter times of day and taking the flu vaccine. A copy of this letter is exhibited at **AGM3WGO01/305- INQ000227258.**

713. Further easy-read guidance was issued at the end of the firebreak period, on the 5 November 2020 on how to take extra care as more people get coronavirus. This included the same advice as in the October guidance with the addition of mask-wearing inside public places. A copy of this guidance is exhibited at **AGM3WGO01/306 - INQ000081602.**

714. On 17 December 2020 Christmas advice for people who were shielding was issued. A copy of this is provided in exhibit **AGM3WGO01/307 - INQ000081669.** This advice, although separate to the Coronavirus Action Plan for Wales which introduced 'Alert levels' in Wales, clarified the additional actions those who were CEV should be considering as incidence of coronavirus increases or decreases, linked to the alert levels without the need to communicate more formally with each change. It noted that those who were CEV could choose to be part of a Christmas bubble but advised that this involved greater risks, and the risk of infection would be minimised by limiting social contact with people outside the household. For those joining a Christmas bubble, social distancing, regular handwashing, surface cleaning, ventilation, going

outdoors, avoiding car-sharing with people outside the household and consideration of face-covering indoors were advised.

715. Unfortunately, on the 22 December 2020 the advice to people in Wales who were CEV changed from this date due to the uncertainties concerning the new variants of concern (at this stage the "Kent variant"). People within this group were advised to no longer attend school or work outside the home. A letter from the Minister for Health and Social Services was issued confirming this advice, exhibit **AGM3WGO01/308 - INQ000227295** refers, but it was recognised given the time of year these letters would be inevitably delayed, and a public announcement was issued with a plea to stakeholders and employers to note the change of advice. A copy of the announcement is exhibited in **AGM3WGO01/309 - INQ000321032.**

716. On the 27 January 2021 further guidance was issued to the CEV advising that they should continue to no longer attend work or school outside the home until to 31 March 2021, as exhibited in **AGM3WGO01/310 - INQ000227306**. This was based on the CMO(W) recommendation made in light of the high incidence of Covid-19 at that time. A copy of this advice is provided in exhibit **AGM3WGO01/311 - INQ000081809.**

717. On the 12 March 2021 the Minister for Health and Social Services announced that on the recommendation of the CMO(W) the advice to the CEV to follow shielding measures would be paused from 1 April 2021. A copy of the guidance issued on 1 April 2021 is exhibited in **AGM3WGO01/312 - INQ000227322** and a copy of the announcement in exhibit **AGM3WGO01/313 - INQ000337551.**

718. Updated guidance was issued on the 11 June 2021 to the CEV. A copy of this is exhibited in **AGM3WGO01/314 - INQ000082105.** At this time shielding advice was still paused, changes made were minor to reflect updates on universal credit, travel and SMS (text) and email alerts.

719. The CMO(W) wrote a letter on 27 July 2021 with advice for people who were CEV to provide guidance as the Covid -19 rules were relaxed. This strongly recommended the vaccine for those who had not yet had it and advised keeping contacts to a minimum, meeting outside where possible, social distancing, avoiding touching the face, wearing a face covering where required and regular hand washing and surface

cleaning. A copy of this letter is exhibited in **AGM3WGO01/315 - INQ000271726.** An easy read version of this letter, dated 27 July 2021, is exhibited in **AGM3WGO01/316 - INQ000082194.**

720. On the 9 September 2021 the UK CMOs recommended that that shielding advice to the CEV group should no longer form part of the Covid-19 response and that it was appropriate to return to the pre-pandemic approach of individual clinical advice. The SPL remained open in Wales however advice was still paused.

721. On the 23 December 2021 the Minister for Health and Social Services issued a statement confirming that the Chief Medical Officer was writing to everyone on the SPL with advice on minimising their risk due to the increase in the rate of the new omicron variant. A copy of this statement is provided in exhibit **AGM3WGO01/317 - INQ000227352.** The Chief Medical Officer's letter, exhibited at **AGM3WGO01/318 - INQ000353303,** explained that the Omicron variant could quickly move from person to person and highlighted the need for regular hand washing, wearing a face covering, indoor ventilation and the taking of a lateral flow test before going to busy places or visiting friends and family. The letter also strongly encouraged a booster in addition to the two vaccine doses.

722. The CEV guidance was updated on 25 January 2022, confirming that those under 18 were no longer considered CEV or on the SPL and highlighting the Chief Medical Officer's December 2021 letter regarding the Omicron variant. A copy of this guidance is exhibited in **AGM3WGO01/319 – INQ000080897.**

723. On the 17 March 2022, the CMO(W) issued advice to the CEV confirming that the SPL would close on the 31 March 2022. A copy of this is provided in exhibit **AGM3WGO01/320 – INQ000252541.** On the 31 March 2022 shielding programme in Wales officially closed and a copy of the announcement is provided in exhibit **AGM3WGO01/321– INQ000227382**.

Dissemination of advice and guidance to the clinically vulnerable and extremely vulnerable.

724. As outlined above information for the CV and CEV was provided frequently throughout the pandemic. The dissemination of advice and guidance was typically via letters to

individuals, but we also worked closely with primary care, community care and local authorities to ensure key messages and support were provided to this group.

725. The issue of letters was managed by NWIS. This was a significant task to undertake and there were some issues initially in processing the letters out to individuals. On the 9 April 2020 officials were advised that 13,000 of the 91,000 Phase I letters were delayed from reaching eligible individuals due to being sent to previous addresses. A number of patients that were correctly identified as eligible for a shielding letter had a previous address listed due to the version of the Welsh Demographic Service ("WDS") that had been used to match against the name and date of birth during the process the NWIS team undertook. The data that went to local authorities and supermarkets was however correct as it used the Master Patient Index ("MPI") which included the most up to date information for patient addresses therefore local authority support and priority slots were still provided. All parties (NWIS, Delivery Unit and Shared Services) worked to ensure the correct addresses were identified for these individuals and letters were issued to them urgently. As NWIS were responsible for the data breach they contacted the Information Commissioner immediately. A copy of the confirmation of the referral is provided in exhibit **AGM3WGO01/322 – INQ000227050.**

726. While the NHS systems had addresses and postcodes, those details did not automatically translate to local authority areas in order to ensure individuals were signposted to the correct areas for support. As a result, the SPL list was processed by Newport City Council and by GeoPlace so that local authorities could be supplied with the Unique Property Reference Number ("UPRN") for individuals on the SPL in their areas. To facilitate these arrangements a Coronavirus Essential Data Sharing Record was put in place and kept under review, as exhibited in **AGM3WGO01/323 – INQ000227289.** This approach signed off by the Data Protection Officer for the Welsh *Government and the Information Commissioner ("ICO") was informed.*

Support provided by or on behalf of the Welsh Government for the CEV

727. There were a lot of aspects to the shielding programme that needed to be considered and which would require a cross government response, particularly in respect of ensuring appropriate support was in place for this cohort. Amelia John, Deputy

Director was asked to act as the Senior Responsible Officer ("SRO") to coordinate the Welsh Government response to supporting vulnerable people.

728. On the 18 March 2020 the First Minister met with the WGLA and Wales Council for Voluntary Action ("WCVA") to discuss what support could be put in place for people socially distancing. The pre-meeting briefing to the FM noted that the purpose of the meeting was not only to consider those clinically vulnerable but a wider cohort such as those who may be older without a support network, those suffering poor mental health, army veterans and so on. A copy of this briefing to the First Minister is exhibited in **AGM3WGO01/324 – INQ000226957.**

729. Early March 2020 discussions commenced with Age Cymru about the development of the 'Ffrind mewn Angen'/ 'Friend in Need' (befriending service) through all Regional Partnership Boards. Advice and recommendations for funding this service was provided to the Minister for Health and Social Services, a copy of which is exhibited in **AGM3WGO01/325 – INQ000144855.**

730. Wales' 22 local authorities and the Welsh Government worked closely with the WCVA to ensure everyone who was advised to socially distance or shield and needed support would be able to access it in their local community. From the 23 March 2020 to ensure engagement and involvement in policy making, Welsh Government officials held daily meetings with WLGA and WCVA, these were not minute or formal meetings but provided a helpful touch point to collect actions and progress at pace. These meetings moved to three times a week in later months. These meetings covered hot issues and risks, allowed all parties to air concerns and ensured delivery by local government and the third sector of the various elements of the support for shielding people.

731. On the 27 March 2020, following agreement of the Minister for Environment, Energy and Rural Affairs, the Minister for Finance and Trefnydd and the First Minister, the Welsh Government announced £24m to support Wales's voluntary sector in response to the pandemic and a further £15m to cover the purchase and delivery of food boxes to ensure people in Wales who not able to leave their home are able to get free direct deliveries of food and other essential items to their door. A copy of the advice and

recommendations for agreement to Ministers is exhibited in **AGM3WGO01/326 – INQ000226977.**

732. On the 3 April 2020 the Welsh Government confirmed the first food-box deliveries were made to the shielded group. The boxes were delivered by Bidfood and Brakes, two large foodservice companies.

733. On the 6 April 2020 the Minister for Health and Social Services Minister for Housing and Local Government, Julie James AM ("MHLG"), Minster for Energy, Environment and Rural Affairs, Lesley Griffiths AM ("MEERA") and Deputy Minister and Chief Whip, Jane Hutt AM ("DM&CW") met virtually to discuss shielding delivery, volunteering and the wider vulnerable group in relation to Covid-19. During the meeting, the Minister for Health and Social Services highlighted that Wales has an older, sicker, poorer population than England, so is likely to have a higher proportion of these vulnerable people relative to population. Actions from the meeting included MEERA to look into Sainsbury's self-registration system's rejection of Welsh postcodes; DMCW to check England's response to the shielded list and the MHLG to consider broader approach to service delivery for vulnerable groups once shielded rollout is completed. A copy of this meeting note is exhibited in **AGM3WGO01/327- INQ000227041.**

734. On 8 April 2020 Food and Other Essential Supplies to the Vulnerable Task Force met. This included Ministers and Permanent Under Secretaries from the UK Department for Environment, Food and Rural Affairs ("DEFRA"), UK Ministry of Housing, Communities & Local Government ("MCHLG"), UK Department of Education ("DFE"), UK Department of Work and Pensions ("DWP"), Department of Health and Social Care ("DHSC"), with representatives from the devolved governments. For Wales the MEERA attended. DEFRA provided an update on operations in England, particularly around access to food delivery slots. Also discussed at this meeting were the proposals to support the non-shielded vulnerable population to access food and essential supplies which had been previously agreed at the General Public Sector Ministerial Implementation Group ("GPSMIG") on 3 April 2020. Discussion included the need to do something specific for elderly and whether this should this be over 70 (9 million individuals in the UK) or over 75 (5 million individuals in the UK) and whether a definition of "vulnerable people" had been made. DEFRA confirmed that no

definition for 'vulnerable people', but they were working with MHCLG, DWP, and DFE. Concerns raised included the need to include children within scope of vulnerable people, to understand volumes of various cohorts and the potential impact on existing services, to plan for an exit strategy post Covid-19 and to cater for individuals having English as a second language. A copy of the note for this meeting is provided in exhibit **AGM3WGO01/328 - INQ000227047** and a supporting paper for the meeting is exhibited in **AGM3WGO01/329 - INQ000227422.**

735. Early May 2020 arrangements were entered into with the National Pharmacy Association, third sector organisations and the Royal Mail for a new volunteer prescription delivery scheme.

736. Following the August pause in shielding advice, the food box deliveries ended and, on the 30 September 2020, the National Volunteer Prescription Delivery Scheme and the Royal Mail Track 24 Click and Drop Scheme was paused. Provision of priority slots for supermarket deliveries, which the Welsh Government facilitated by providing supermarkets with CEV patient addresses, continued for some time after.

737. The number of on the Shielding Patient List as on the 29 March 2021, when the advice was paused is set out below.

Table 11: Number of Shielding Patients on 29 March 2021

Age Group	Shielding population	Total Population	Proportion of Total Population on Shielded Patient List (per 1,000 people)
Under 16	2,350	563,835	4.2
16 - 69	79,910	2,108,810	37.9
70 and over	56,210	480,234	117.0
All ages	138,470	3,152,879	43.9

Assessment of the impact of shielding on the clinically vulnerable and clinically extremely vulnerable

738. As outlined above we were very conscious of the impact that asking people to shield would have. These individuals were CEV, and it was important that they did not become isolated, particularly from health services. On the 6 March 2020 a video consultation service was rolled out to all GP practices in Wales. I am not aware of any specific difficulties with the video consultation service, including access to technology for patients or GPs that the Welsh Government made aware of. As outlined in a briefing to the Health Social Care and Sports Committee on the 30 September 2020, exhibit **AGM3WGO01/330- INQ000368345,** feedback on the all-Wales rollout of video consultation to all GP surgeries, community care settings and secondary care (outpatients) settings had been positive. At that time over 15000 consultations had been undertaken across Primary, Secondary and Community Care settings. Feedback from patients who received virtual care was very supportive of the system, with 97% of patient's rating this new way or working as excellent, really good or good. Clinicians using the service also agreed. We were however conscious of the need to support access to digital services and further information on the work supported by the Welsh Government to support access to technology is detailed below in paragraph 743.

739. On the 5 April 2020 arrangements were entered into with the National Pharmacy Association (NPA) to provide additional capacity to the existing medicines delivery service provided by community pharmacies in Wales which would assist those isolating or shielding ar home.

740. I wrote to the NHS bodies on the 5 May 2020 setting out a number of actions health boards needed to take to ensure cancer services provision. This included action to put in place support systems able to deal with concerns from cancer patients regarding social isolation, shielding and the likely benefits and harms of ongoing cancer care. A copy of this letter is exhibited above at AGM3WGO01/273 - INQ000227155.

741. As outlined in Part A of this statement, due to the urgency of the situation decisions at the start of the Covid-19 pandemic were often made without a formal assessment of the impact on vulnerable people. That is not to say that there was not an assessment and review of impacts from the shielding programme. On the 19 August

2020 the integrated impact assessments on shielding and food boxes were published. As also detailed above in paragraph 233 these outlined:

a. AGM3WGO01/53- INQ000066205 – **The Impact of Shielding on Vulnerable Individuals: Integrated Impact Assessment** found that:

    i. the proposal had been developed at pace to respond proportionately and effectively to developing events in respect of Covid-19. The involvement of a wide range of stakeholders ensured that those affected by the proposals were adequately represented in its formulation.

    ii. The most significant impact 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.

    iii. The long-term impact of not responding to the food, medicines and support needs of the shielding group would have been serious for that group and their family, friends and communities and for public services.

    iv. Providing support and assistance (e.g. social support around loneliness and isolation) through local authorities prevented potential serious mental and physical ill health, which in turn would have had long term detrimental impact on both shielding people, communities and public services.

b. AGM3WGO01/54 - INQ000087136 - **Food Boxes for Shielded People: Integrated Impact Assessment** found that

    i. The food box delivery scheme had been developed at pace, meaning that it had not been possible to engage stakeholders in the normal way, but local authorities had been involved in the initial consultation in the development of the scheme and specialise nutritionists and dieticians within Wales had been consulted about the contents of the food boxes.

    ii. The most significant impact of the scheme had been positive, with the creation of an infrastructure and methodology for ensuring that access to food could be provided to those shielding thus keeping them safe.

iii. Not implementing the scheme could have led to shielding individuals not obtaining the services and provisions they require or to breaking self-isolation guidelines to do so.

iv. Local authorities supported the scheme by handling queries and registering people. Regular meetings were held with the WLGA, WCVA from March to July. The Welsh Government also worked with military planners and suppliers to ensure the scheme was implemented at pace, with deliver of the first boxes within 7 days of registering.

742. Analysis of the characteristics of those on the SPL was also undertaken by the Welsh Government's Knowledge and Analytical Service ("KAS") using the National Survey for Wales data. In August 2020 KAS undertook an analysis of those on the SPL access to green spaces. A copy of this analysis is exhibited in **AGM3WGO01/331 - INQ000227225.** In 2021 analysis was undertaken exploring whether the people on the SPL also had other non-clinical vulnerabilities. A copy of this analysis is exhibited in **AGM3WGO01/332- INQ000227381.**

Use of Technology during the Pandemic

743. The use of technology during the pandemic played a key role in ensuring access to healthcare services. Prior to the pandemic period there was a clear and well documented need to transform health and care delivery across Wales. 'A Healthier Wales' highlighted digital as an enabler of transformation for almost all that we do in the modern healthcare system and the role of digital services in ensuring the transformation of services was documented in the Digital Health and Care Strategy for Wales, a copy of which is provided in exhibit **AGM3WGO01/333-INQ000215604**[90]**.**During the course of the pandemic period, it was clear that digital was a major enabler for an effective and timely response to Covid-19.

744. The Technology and Digital Transformation Directorate was responsible for delivery of the Digital Health and Care Strategy for Wales. I have sought information and

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

support from Phillip Bowen, Deputy Director in the Technology, Digital and Innovation Directorate to support this section of my statement.

745. During the pandemic, the Covid-19 Digital Cell ("Digital Cell") was established and ran from March 2020 to September 2021. The Digital Cell was established to lead and co-ordinate all aspects of digital health response to Covid-19 for Wales, as part of wider Covid-19 co-ordination and response arrangements. The position of the Digital Cell in the Covid-19 Planning and Response structure is outlined earlier in my statement in Part A. A copy of the Digital Cell's terms of reference is exhibited in **AGM3WGO01/334 - INQ000226974**. The Cell met as frequently as the work required of it demanded.

746. The Cell formally drew together senior officials from Health and Social Services Group, NWIS, and NHS Wales organisations to support the work required to manage the outbreak of COVID-19 in Wales. The Cell led the digital health response, making collective decisions and recommendations as appropriate. A list of the Digital Cell usual attendees is exhibited in **AGM3WGO01/335 - INQ000227424.**

747. The Digital Cell oversaw the use of technology within the healthcare system. In order to support remote working we accelerated the national Office 365 programme, provided the ability for GP remote desktop connectivity and supported programmes which provided digital services for professional's patients and the public. The rapid rollout of consultant connect and attend anywhere also supported the ability for virtual consultations to take place across primary and secondary care these are examples of implementing technology achieved in days and weeks that would normally have taken years in professional negotiation and commercial procurement. There were further plans to expand the broadband width and increase VPN licences to support home working, was continuing to review the network infrastructure and cyber security. The Health and Social Services Group and digital cell worked closely with Digital Communities Wales to support digital exclusion as well as providing support to care homes across Wales. Digital Communities Wales is a Welsh Government funded programme which is delivered by Cwmpas (formerly Wales Co-operative Centre) in partnership with the Good Things Foundation and Swansea University. The programme began in 2019 and will run until June 2025. Cwmpas has been delivering

digital inclusion programmes in Wales since 2005 with the aim of providing people with the skills and confidence to feel more included and to take more control of their own lives. This digital legacy that was created was vitally important through the recovery phase and in our continued implementation of the vision set out in 'A Healthier Wales'.

748. I have outlined below in more detail the advice provided by the Health and Social Services Group to the Minister for Health and Social Services on the action needed to allow appointments, meetings (including multi-disciplinary and team) and document/diagnostic review to take place remotely:

749. In response to Ministerial Advice dated 6 March 2020 the Welsh Government funded the rapid national roll out of the AttendAnywhere platform in Primary Care GP surgeries. AttendAnywhere is a web-based video consultation system. The initial roll out required funding of £1.692m, which included the annual licencing cost of £0.792m and other costs related to the significant upscale of support for the roll out. The technological infrastructure already existed across the NHS estate and the roll out was carried out health board by health board by the Digital and Technology Team and Technology Enabled Care Cymru (TEC Cymru). TEC Cymru are a multi-disciplinary team funded by the Welsh Government and hosted by Aneurin Bevan University Health Board that provides oversight and direction to Technology Enabled Care in Wales. A copy of this advice is provided in **AGM3WGO01/336 - INQ000226926.**

750. The Wales Cooperative Centre, as the delivery body for Digital Communities Wales operated a Device Loan Scheme which loaned out devices to pubic bodies and third sector organisations to use with their clients as a result of advice submitted on 27 March 2020 funding of £553,000 was provided by the Welsh Government to extend the device loan scheme to include care homes and wards where there was existing broadband, as well as providing remote training and support to staff. The additional funding was sought to purchase an additional 1,100 devices (50 per local authority).

751. This extension was aimed at supporting people to access information and remote health services, such as video consultations with their healthcare provider during the pandemic period. A copy of this advice is provided in **AGM3WGO01/337 - INQ000136772.**

752. On the 6 April 2020 advice to the Minister for Health and Social Services recommended the rapid expansion of NHS Wales Video Consultation Service into Secondary and Community Care sectors. This advice proposed the immediate expansion of the NHS Wales Video Consultation service into both Secondary and Community Care sectors at pace. This proposal was driven by a clinical need for video consultation services in response to the COVID-19 pandemic and for the long term change in the delivery of NHS services. A copy of this advice is provided in **AGM3WGO01/338 - INQ000136773.**

753. On the 30 June 2020 advice to the Minister for Health and Social Services recommended an extension of the NHS Wales Video Consultation Service into Pharmacy, Optometry & Dentistry. The NHS Wales Video Consultation Service was a successful tool in the rapid transformation of healthcare services during the COVID-19 response. As a result, there was significant clinical demand for the extension of the service into pharmacy, optometry and dentistry. A copy of this advice is provided in **AGM3WGO01/339 - INQ000116640.**

754. While there was no formal impact assessment undertaken and although not always explicit in the submission of advice or recommendations to the Minister for Health and Social Services there was consideration of the impacts of the recommendations on the elderly or disabled as well as those for whom there may be language barriers or digital access issues (such as the homeless or those with poor internet connection). This consideration was part of a wider policy agenda and aligned the pre-pandemic long-term transformational policy set out in 'A Healthier Wales' which incorporated access issues also set out in Welsh Government frameworks and strategies including all Wales strategy for digital health set out in 2015 in Informed Health and Care: A Digital Health and Care Strategy for Wales under which local health boards developed their own digital strategies, reflected in their Integrated Medium Term Plans (IMTPs).

755. The rapid roll out of the video consultation service was key to enabling: -

    a. Improving treatment in patient's own homes so easing access to medical services for vulnerable groups, including those with reduced mobility or limited transport options.

b. Timely triage; potentially keeping patients out of hospital and enabling better self-care. People not travelling also reduced the Covid-19 infection risk.

c. Multiple participants to be invited into the consultation, specialist consultants can attend, as well as family who live further away to assist in communication and understanding.

756. The work of the Technology and Digital Transformation Directorate and Digital Cell went beyond enabling appointments, meetings (including multi-disciplinary and team) and document/diagnostic review to take place remotely. They played significant roles in the use of technology in relation to contact tracing and the vaccine programme, which I understand will be covered in later modules, but I do want to highlight this work and thank those involved in the Welsh Government and the NHS for their incredible efforts to deliver during the pandemic period.

757. On the 23 March 2021 an updated Digital Strategy for Wales was published, a copy of which is exhibited in **AGM3WGO01/340** - INQ000227425 which set out the aim to accelerate the benefits of digital innovation for people, public services and across our business community. This reflected on the work that had been done not only in the healthcare system but across public services to develop digital solutions.

758. In relation to the healthcare system, from 2021 DHCW is tasked with taking forward the next generation of services needed to transform health and care delivery at a national level. One example is the Digital Services for Patients and Public ("DSPP") Programme, which was set up in March 2021, and which DHCW is responsible for, which will build upon the developments made during the pandemic period and help people in Wales to access better healthcare and support health providers to deliver care more efficiently. The DSPP's current deliverable is the development of the NHS Wales App which is currently being trialled by a number of GP practices and patients. The App, and its accompanying website, represents the single, patient-facing entry point for digital health and social care services in Wales and will provide a platform for future digital services. Feedback from the increasing number of people using the App will be invaluable as we develop the App further and produce additional services. From the beginning, people have been at the heart of developing the App – a major

lesson learned from the successful delivery and management of Covid-19 digital services.

Future Risks and lessons learned

759. A chronological list and copies of all internal or external reviews, lessons learned exercises or similar produced or commissioned by the Welsh Government relating the issues in Module 3 since 1 March 2020 is exhibited in **AGM3WGO01/341 - INQ000227413.** This is a significant list of exercises and will be subject to a separate detailed statement reviewing this work, but I will provide my personal reflections on the lessons learned during this period and highlight some of what I consider to be helpful overviews for the Inquiry.

760. Throughout the Covid-19 pandemic our health and social care systems faced the biggest challenge of our lifetimes. Colleagues across the Health and Social Services Group and NHS Wales adapted to new ways of working to respond quickly to the need to continue to deliver essential services in a safe environment. As I have outlined NHS Wales was working closer together and with Welsh Government and Local Government than it ever had before and introduce new ways of working at a pace never seen before. During a crisis we look at issues differently and take instinctive action that challenges the status quo. As Director General Health and Social Services and Chief Executive NHS Wales I saw many examples of innovative practice during the Covid-19 pandemic response, and it was essential to capture this and ensure we took the opportunity to learn the valuable lessons arising as a result.

761. My four Accountable Officer letters to the Permanent Secretary, set out at the start of this statement[91], provide my view at the time on how we learned from experience. They also show other important factors: for example, how we ensured assurance across the health sector through the use of quarterly frameworks (as outlined and exhibited in paragraph 202 above) addressing particular risks or issues; how we put administrative arrangements in place (such as the Health and Social Services Group Covid-19 Planning and Response Group) which provided consistent briefing and communications across the Welsh healthcare system; and how we worked with

[91] See exhibits AGM3WGO01/01 INQ000182427; AGM3WGO01/02- INQ000227296; AGM3WGO01/03- INQ000083233 and AGM3WGO01/04- INQ000083234

partners to support the pandemic response (for example, by drawing upon the advice and expertise of the Army's logistical specialists).

762. Some of the changes brought in, especially around the digitalisation of NHS services, built on the foundations and vision set out in 'A Healthier Wales'. The Welsh Government's and NHS Wales' collective response to Covid-19 accelerated the implementation of our long-term plan in some areas.

763. I have in this statement sought to address as fully and succinctly as possible the request made by the Inquiry set out in M3/WGO/01. This request covered a significant range of the Health and Social Services Group and NHS activities during the pandemic period, and I am hugely grateful to colleagues in the Health and Social Services Group who have assisted in collating information for me to review and exhibit in this statement.

764. It is important to acknowledge that this statement does not cover the entirety of the Health and Social Services Group or NHS's activities during the pandemic period but deliberately focusses on the Covid-19 response arrangements. The pressure on those working in and supporting the health care system in Wales was relentless and undoubtedly there are lessons to learn and ways we can improve however I am truly grateful and proud of the work that was done.

Statement of Truth

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

Signed: **Name Redacted**

Andrew Goodall

Dated: 10 May 2024

Annex 1 – List of all Directors and Deputy Directors in the Health and Social Services Group

	Name	Post Title	From	Until
1	Alan Brace	Director of Finance	12/09/2016	30/06/2021
2	Albert Heaney	Chief Social Care Officer for Wales	01/07/2015	
3	Alex Slade	Deputy Director for Primary Care	22/08/2019	28/02/2022
4	Alex Slade	Director of Community, Primary Care, Mental Health & Vulnerable	01/03/2022	31/03/2022
5	Alex Slade	Director of Primary Care and Mental Health	01/04/2022	
6	Alistair Davey	Deputy Director, Enabling People	01/07/2015	31/03/2022
7	Alistair Davey	Deputy Director Social Services Enabling	01/04/2022	
8	Andrea Street	Deputy Director Improvement	26/01/2017	31/03/2022
9	Andrea Street	Deputy Director Social Services Improvement	01/04/2022	19/06/2022
10	Andrew Dickenson	Chief Dental Officer	01/04/2022	
11	Andrew Evans	Chief Pharmaceutical Officer	08/08/2016	
12	Andrew Goodall	DG Health/NHS Chief Executive	01/07/2015	31/10/2021
13	Andrew Havers	Senior Medical Officer for Primary Care	06/01/2020	04/08/2022
14	Anthony Jordan	Deputy Director, Inclusion & Corporate Business	02/11/2020	31/08/2021
15	Anthony Jordan	Deputy Director, Enabling People	01/11/2021	10/01/2022

16	NR	Mass Testing Planning Team - Military Planner	13/11/2020	14/12/2020
17	Carla Giudice	Deputy Director Contact Tracing	12/07/2021	06/02/2022
18	Chris Brereton	Chief Environmental Health Officer	01/04/2020	30/06/2020
19	Chris Jones	Deputy Director - Covid Certification	01/07/2021	31/03/2022
20	Chris Jones	Deputy Director - Covid Certification	01/04/2022	19/05/2022
21	Chris Jones	Deputy Director of COVID-19 Vaccination Policy and Programme	20/05/2022	
22	Chris Jones	Deputy Chief Medical Officer	01/01/2018	
23	Chrishan Kamalan	Coronavirus Response	26/02/2020	31/08/2020
24	Claire Rowlands	Interim Director of Vaccine	13/01/2021	31/03/2022
25	Claire Rowlands	Interim Director of Vaccine	01/04/2022	
26	Colette Bridgman	Chief Dental Officer	15/11/2019	31/07/2021
27	Dafydd Evans	Deputy Director EU International	01/09/2020	31/03/2022
28	Dafydd Evans	Deputy Director Life Sciences and Innovation	01/04/2022	
29	David O'Sullivan	Chief Optometric Adviser	01/07/2019	31/08/2022
30	Ed Wilson	Deputy Director Public Health Improvement Prevention & Promo	14/06/2021	31/03/2022
31	Ed Wilson	DD, Public Health, Improvements & Inequalities	01/04/2022	
32	Emma Coles	Deputy Director, Workforce and OD	18/11/2019	31/03/2022

33	Emma Coles	Deputy Director, Workforce and OD	01/04/2022	
34	Emma Spear	Deputy Director, Transformation Strategy	01/11/2019	31/03/2022
35	Emma Spear	Deputy Director, Office of the DG	01/04/2022	
36	Ffion Thomas	Deputy Director of Operations	08/01/2021	21/03/2021
37	Fliss Bennee	Deputy Director for Technology & Digital	23/10/2019	13/05/2020
38	Fliss Bennee	Co-Chair of TAC	14/05/2020	
39	Frances Duffy	Director of Primary Care and Health Science	01/05/2019	31/10/2021
40	Frank Atherton	Chief Medical Officer	01/08/2016	
41	Gareth Howells	Chief Nursing Officer	26/03/2021	29/08/2021
42	Gemma Nye	Deputy Director Public Health Improvement Prevention & Promo	01/02/2021	01/08/2021
43	Gillian Richardson	Senior Professional Advisor	01/04/2020	31/03/2022
44	Gillian Richardson	Senior Professional Advisor	01/04/2022	30/06/2022
45	Glyn Jones	Chief Statistician (Deputy Director)	01/07/2015	19/07/2020
46	NR	Mass Testing Planning Team - Military Planner	13/11/2020	14/12/2020
47	Heather Payne	Senior Medical Officer for Maternal & Child Health	01/06/2018	
48	Helen Arthur	Director of Workforce and Corporate Business	12/04/2018	31/03/2022
49	Helen Arthur	Director of Workforce and Corporate Business	01/04/2022	

50	Huw Brunt	Chief Environmental Public Health Officer	04/01/2021	31/03/2022
51	Huw Brunt	Chief Environmental Public Health Officer	01/04/2022	
52	Ian Gunney	Deputy Director of Capital Estates & Facilities	18/08/2020	31/03/2022
53	Ian Gunney	Deputy Director of Capital Estates & Facilities	01/04/2022	
54	Ifan Evans	Director - Technology, Digital & Transformation	01/08/2018	31/03/2022
55	Irfon Rees	Director of Population Health	07/06/2021	31/03/2022
56	Irfon Rees	Director of Health and Wellbeing	01/04/2022	
57	Janet Davies	Head of Cwm Taf Morgannwg Intervention Team	03/06/2019	31/03/2022
58	Janet Davies	Head of Cwm Taf Morgannwg Intervention Team	01/04/2022	31/05/2022
59	Jean White	Chief Nursing Officer	01/07/2015	06/04/2021
60	Joanna Jordan	Head of Health and Social Services Group Group	01/04/2021	31/03/2022
61	Jo-Anne Daniels	Director of Health, Vulnerable Groups and NHS Governance	14/10/2019	31/03/2022
62	Judith Paget	DG Health/NHS Chief Executive	01/11/2021	31/03/2022
63	Judith Paget	DG Health/NHS Chief Executive	01/04/2022	
64	Kieran Walshe	Head of NISCHR	01/10/2019	31/03/2022
65	Kieran Walshe	DD Healthcare & Research	01/04/2022	
66	Leon Wong	Deputy Director for Health Science	01/05/2021	31/03/2022
67	Leon Wong	Deputy Director for Health Science	01/04/2022	

68	Lisa Wise	Deputy Director, Operation Supplies (PPE)	16/11/2020	31/03/2022
69	Lisa Wise	HSC Climate Change and Environmental Public Health	01/04/2022	
70	Liz Davies	Senior Medical Officer - Mental Health and Vulnerable Groups	02/12/2019	
71	Marion Lyons	Senior Medical Officer	01/03/2017	31/03/2022
72	Marion Lyons	Adviser - Health Protection	01/04/2022	
73	Mark Walker	Senior Medical Officer for Primary Care	13/02/2020	31/03/2022
74	Mark Walker	Senior Medical Officer for Primary Care	01/04/2022	12/09/2022
75	Matthew Denham-Jones	Deputy Director of Finance, HSSDG	13/12/2021	31/03/2022
76	Matthew Denham-Jones	Deputy Director of Finance, HSSDG	01/04/2022	
77	Matthew Jenkins	Deputy Director, Partnership and Cooperation	02/07/2018	31/03/2022
78	Matthew Jenkins	Deputy Director Futures & Integration	01/04/2022	
79	Matthew Pinnell	Deputy Chief Executive	07/03/2018	31/03/2022
80	Matthew Pinnell	Deputy Chief Executive	01/04/2022	
81	Meirion Evans	Consultant in Communicable Disease Control	06/04/2020	30/06/2020
82	Mike Connolly	Deputy Director Testing	26/07/2021	31/03/2022
83	Mike Connolly	Deputy Director Testing	01/04/2022	22/05/2022
84	NR	Mass Testing Planning Team - Military Planner	13/11/2020	31/01/2021

85	Neil Surman	Deputy Director, Public Health	08/10/2018	25/02/2020
86	Neil Surman	Coronavirus Bill	26/02/2020	01/11/2020
87	Nia Roberts	Deputy Director Testing	09/11/2020	08/08/2021
88	Nia Roberts	Head of Escalation & Special Measures Support	20/12/2021	30/01/2022
89	Nia Roberts	Deputy Director Contact Tracing	31/01/2022	31/03/2022
90	Nia Roberts	Deputy Director	01/04/2022	
91	Nick Batey	Deputy Director for Technology & Digital	01/06/2020	14/06/2020
92	Nick Batey	Deputy Director for Technology & Digital	01/10/2020	15/09/2021
93	Nick Wood	Deputy Chief Executive NHS Wales	06/12/2021	
94	Nigel Brown	Chief Executive of Cafcass Cymru	14/12/2017	
95	Peter Jones	Deputy Director of Operations	20/05/2019	19/05/2020
96	Peter Jones	Deputy Director, Public Health	20/05/2020	31/03/2022
97	Peter Jones	Deputy Director	01/04/2022	
98	Philip Bowen	Deputy Director, Programme Delivery, Test Trace Protect	01/12/2020	31/03/2022
99	Philip Bowen	Deputy Director Digital Policy and Delivery	01/04/2022	
100	Rhian Gibson	Deputy Director of Vaccine	17/05/2021	05/12/2021
101	Rhiannon Ivens	Deputy Director, Inclusion & Corporate Business	12/04/2021	31/03/2022
102	Rhiannon Ivens	Deputy Director, Inclusion & Corporate Business	01/04/2022	02/10/2022
103	Richard Sewell	Deputy Director Contact Tracing	18/05/2020	06/12/2020

104	Rob Orford	Chief Scientific Adviser for Health	03/01/2017	
105	Sara Hayes	SMO - support	03/04/2020	30/06/2021
106	Sarah Watkins	WG/NHS Mental Health Incident Group Support	30/03/2020	01/09/2020
107	Simon Dean	Deputy Chief Executive NHS Wales	29/02/2016	31/12/2021
108	Simon Phillips	Deputy Director Strategic Information Hub Co-ordinator	12/04/2021	31/03/2022
109	Simon Phillips	Deputy Director Change & Improvement	01/04/2022	
110	Sioned Rees	Head of Escalation & Special Measures Support	31/07/2015	31/03/2022
111	Sioned Rees	Head of Escalation & Special Measures Support	01/04/2022	25/05/2022
112	Sioned Rees	Temporary Public Health Protection Director	26/05/2022	
113	Stephanie Howarth	Chief Statistician (Deputy Director)	20/07/2020	31/01/2021
114	Steve Elliot	Deputy Director of Finance, HSSDG	24/03/2017	29/06/2021
115	Steve Elliot	Director of Finance	30/06/2021	31/03/2022
116	Steve Elliot	Director of Finance	01/04/2022	
117	Steve Probert	Deputy Director of Operations	28/09/2020	31/03/2022
118	Steve Probert	Deputy Director Corporate Services & Government Business	01/04/2022	
119	Steven Marshall	Chief Social Research Officer	01/07/2015	31/01/2021
120	Sue Tranka	Chief Nursing Officer	30/08/2021	31/03/2022
121	Sue Tranka	Chief Nursing Officer	01/04/2022	

122	Tania Nicholson	Deputy Director of Vaccine	11/01/2021	31/03/2021
123	Tania Nicholson	Deputy Director Vaccination Policy	30/09/2021	29/09/2022
124	Tom Taylor	Deputy Director Contact Tracing	23/11/2020	19/09/2021
125	Tracey Breheny	Deputy Director of MH, Substance Misuse & Vulnerable Groups	21/01/2019	31/03/2022
126	Tracey Breheny	Deputy Director Mental Health and Vulnerable Groups	01/04/2022	
127	Valerie Whiting	Deputy Director of Capital Estates & Facilities	10/12/2019	23/02/2021

Annex 2 – List of Policies and Guidance related to scope of Module 3

Document Name	Control Number	Document Date	Description
Circular- Health board allocations: 2021 to 2022 (WHC/2020/025)	INQ000421653	2020-01-05	Letter to health boards about funding arrangements for the financial year 2021 to 2022 and notes that allocation does not include funding for the ongoing response to Covid-19.
COVID-19 workforce risk assessment tool	INQ000080841	2020-02-23	A risk assessment tool to help people working in the NHS in Wales to see if they are at higher risk of developing more serious symptoms if they come into contact with the Covid-19 virus.
Coronavirus (COVID-19) – Key changes to testing criteria	INQ000080850	2020-03-13	Provides advice from the Chief Medical Officer on changes to testing criteria, including testing of health care workers.
Coronavirus (COVID-19): key changes to testing criteria	INQ000080856	2020-03-18	Letter from the Chief Pharmaceutical Officer which sets out the steps which the Welsh Government took immediate to reduce the impact of the new and increasing challenges community pharmacies in Wales faced as a result of the Covid-19 situation.
Supporting allied health professionals and allied health professional support workers during the COVID-19 epidemic in the UK	INQ000080864	2020-03-19	Letter signed by NR (and others) providing support to allied health professionals and allied health professional support worked during the Covid-19 epidemic in the UK.
Self-isolation: Stay at home guidance for households with possible coronavirus	INQ000080862	19-03-2020	Guidance on managing covid-19 at home
COVID-19: guidance for additional nursing and midwifery workforce	INQ000080868	2020-03-20	Guidance for additional nursing and midwifery workforce to help with coronavirus.
Returning pharmacists and pharmacy technicians: guidance	INQ000080870	2020-03-20	Guidance for returning allied health professionals and healthcare scientists.

Document Name	Control Number	Document Date	Description
Letter from Chief Dental Officer: Covid 19 Red alert level 1	INQ000080876	2020-03-23	Red alert phase to signify when social distancing measured need to be adhered to.
Red Alert Phase Escalation	INQ000080874	2020-03-23	Red alert phase to signify when social distancing measured need to be adhered to.
Red Alert Phase Dental Annex guidance	INQ000080875	2020-03-23	Guidance on red alert phase.
Guidance on Protecting People defined on medical grounds as extremely vulnerable from coronaviruses (previously known as shielding)	INQ000080897	2020-03-24	Guidance on shielding.
Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus (COVID-19)	INQ000080896	2020-03-24	Guidance on shielding.
Coronavirus (COVID-19) letter to GPs: shielding patients at highest risk	INQ000080900	2020-03-24	Guidance on shielding.
Visitor guidance to in-patient health settings in times of Coronavirus (COVID-19)	INQ000080902	2020-03-25	Information on severe morbidity and morality from coronavirus.
Coordination of medicines delivery during COVID-19 pandemic	INQ000080915	2020-03-30	Guidance on medicines delivery.
Coronavirus and personal protective equipment (PPE)	INQ000080917	2020-03-30	Guidance on PPE.
Coronavirus Act – Excess death provisions: information and guidance for medical practitioners	INQ000080922	2020-04-01	Information and guidance for medical practitioners on excess death provisions in the Coronavirus Act 2020.

Document Name	Control Number	Document Date	Description
Coronavirus (COVID-19): PPE guidance update	INQ000080942	2020-04-03	Guidance on PPE.
Coronavirus (COVID-19): Letter to GPs: Further information on shielding patients at high risk	INQ000395543	03/04/2020	
Broader vulnerable groups who should strictly follow social distancing guidance – At Risk Group	INQ000080930	03/04/2020	Letter to GPs about high risk extremely vulnerable group
List of those who are extremely vulnerable – High Risk Group	INQ000080931	2020-04-03	Letter to GPs about high risk extremely vulnerable group
CEM CMO Public health Link Appendix 4 Letters to GPs	INQ000080932	2020-04-03	Number of patients in each category
Extremely Vulnerable Groups – Questions and Answers – 2nd April 2020	INQ000080933	2020-04-03	Q&A on shielding
Public Health Link Covid 19 – letter to GPs shielding patients at highest risk	INQ000080934	2020-04-03	CMO letter covering the management and shielding of patients who are at the highest risk of severe morbidity and mortality from coronavirus.
IMPORTANT ADVICE TO KEEP YOU SAFE FROM CORONAVIRUS	INQ000080936	2020-04-03	Letter template to extremely vulnerable people.
COVID-19 – high risk shielded patient list identification methodology	INQ000080937	2020-04-03	High risk shielded patient list identification methodology.
CornonaVirus Letters to GPs further information on shielding patients at high risk	INQ000080938	2020-04-03	Information about the management and shielding of patients who are at high risk of severe morbidity and mortality from coronavirus.
CMO letter to extremely vulnerable people: Support explained	INQ000080944	2020-04-03	CMO letter to extremely vulnerable people.

Document Name	Control Number	Document Date	Description
Doctors returning to the NHS to assist with COVID-19: Guidance	INQ000080948	2020-04-03	Guidance re doctors returning to the NHS to assist with Covid-19.
Novel Coronavirus clinical trials: letter to local health boards and Trusts	INQ000080958	2020-04-06	Information on clinical trials.
Continuation of immunisation programmes during the COVID-19 pandemic: letter from CMO (WHC/2020/006)	INQ000421648	2020-04-06	Letter from CMO on the continuation of immunisation programmes during the Covid-19 pandemic.
COVID-19 Hospital Discharge Service Requirements (Wales) Update to Guidance in respect of Step-up & Step-down Care Arrangements during the COVID-19 period. Issued 29th April 2020	INQ000080975	2020-04-07	Guidance on hospital discharge.
covid-19-discharge-flow-chart	INQ000080960	2020-04-07	Hospital discharge.
Novel coronavirus (2019-nCoV): Advice for healthcare professionals in community settings	INQ000080961	2020-04-07	Discharge requirements reporting template.
COVID Discharge Requirements reporting template	INQ000080962	2020-04-07	Discharge requirements reporting template.
COVID-19 hospital discharge service requirements	INQ000080971	2020-04-07	Covid-19 hospital discharge requirements.
Delayed Discharge Monitoring Submission Template Guidance	INQ000080977	2020-04-07	Guidance on discharge monitoring.
Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from	INQ000080982	2020-04-08	Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus.

Document Name	Control Number	Document Date	Description
coronavirus (COVID-19)			
Dental care during the COVID-19 pandemic: guidance for teams	INQ000080981	2020-04-08	Guidance - Dental care during the COVID-19 pandemic.
Stay safe, stay shielded [Coronavirus (COVID-19): shielding infographic]	INQ000080998	2020-04-10	Shielding infographic.
Coronavirus: ethical values and principles for healthcare delivery framework	INQ000081000	2020-04-12	Coronavirus ethical values and principles healthcare delivery framework.
Considerations for personal protective equipment in the context of acute supply shortages for coronavirus disease 2019 (COVID-19) pandemic	INQ000081012	2020-04-17	Considerations for Personal Protective Equipment in the Context of Acute Supply Shortages for Covid-19.
Joint CMO-CNO letter on DNACPR - English	INQ000081018	2020-04-17	Letter on DNACPR.
Cancer services in Wales during COVID-19Guidance to help health boards plan and deliver critical cancerservices	INQ000081024	2020-04-20	Guidance to help health boards plan and deliver critical cancer services.
Coronavirus: guidance for Local health boards and Independent Hospitals in Wales exercising Hospital Managers' discharge powers under the Mental Health Act 1983	INQ000081030	2020-04-21	Guidance for Local health boards and Independent Hospitals in Wales exercising Hospital Managers' discharge powers under the Mental Health Act 1983.
Information note on delivering the Mental Health (Wales) Measure 2010 during Covid-19 pandemic	INQ000081032	2020-04-21	Guidance on shielding.
Information note on delivering the Mental Health (Wales)	INQ000081036	2020-04-21	Information note on delivering the Mental Health (Wales) Measure 2010 during Covid-19 pandemic

Document Name	Control Number	Document Date	Description
Measure 2010 during Covid-19 pandemic			
Coronavirus (COVID-19) Guidance on protecting people most likely to get very poorly from coronavirus (shielding) [Easy read document]	INQ000081040	2020-04-23	Guidance on shielding.
Hospital discharge service requirements: COVID-19	INQ000081078	2020-04-30	Hospital discharge requirements.
Guidance for Local health boards and NHS Trusts on the reuse of end of life medicines in hospices and care homes	INQ000081081	2020-04-30	Guidance for Local health boards and NHS Trusts on the reuse of end of life medicines in hospices and care homes.
Joint CMO CNO letter on DNA CPR Easy read version	INQ000081082	2020-04-30	Easy read version of letter on DNACPR.
COVID-19 Hospital Discharge Service Requirements (Wales): Addendum to Guidance in respect of funding made available to Health and Social Care partners to support the COVID-19 surge response.	INQ000081086	2020-04-30	Addendum to guidance funding made available to health and social care partners to support Covid-19 surge response.
Covid-19 – Hospital discharge service requirements (Wales) frequently asked questions	INQ000081090	2020-04-30	Hospital discharge service requirements.
Decisions on do not attempt cardiopulmonary resuscitation (DNACPR): age, disability and long	INQ000081091	2020-04-30	Letter on DNACPR.

Document Name	Control Number	Document Date	Description
term conditions [Letter]			
Essential health services during COVID-19	INQ000081106	2020-05-06	Guidance on essential health services.
Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus (COVID-19)	INQ000081108	2020-05-06	Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus.
Overseas trained nurses: join the temporary register	INQ000081110	2020-05-07	Overseas trained nurses - join the temporary register.
Restoration of dental services following COVID-19: guidance	INQ000081124	2020-05-20	De-escalation standard operating processes for primary dental care settings in Wales.
Pandemic influenza preparedness and response plan for dentistry	INQ000081125	2020-05-21	Pandemic influenza preparedness and response plan for dentistry.
Restoration of optometry services post COVID-19 escalation of red alert pandemic plan	INQ000081158	2020-05-31	Restoration of optometry services post COVID-19 escalation of red alert pandemic plan.
Novel Coronavirus (C-19): De-escalation standard operating processes for primary dental care settings in Wales	INQ000081172	2020-06-04	De-escalation of standard operating processes for primary dental care settings in Wales.
Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus (COVID-19)	INQ000081191	2020-06-08	Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus.
Guidance on shielding: Coronavirus (COVID-19) [Easy read version]	INQ000081195	2020-06-10	Guidance on shielding.

Document Name	Control Number	Document Date	Description
Providing Aerosol Generating Procedures (AGP) on non-COVID-19 dental patients: guidance	INQ000081224	2020-06-16	Standard operating process for non-covid-19 dental centres providing AGP in Wales.
Coronavirus (COVID-19) and the Black, Asian and minority ethnic (Black Asian MInority Ethinic) population in Wales	INQ000081237	2020-06-22	Information on the impact of Covid-19 and the black Asian and minority ethnic population, including those who work in the health service.
REHABILITATION NEEDS OF PEOPLE AFFECTED BY THE IMPACT OF COVID-19	INQ000081238	2020-06-22	Rehabilitation needs of people affected by the impact of Covid-19.
People at increased risk from coronavirus	INQ000081307	2020-07-20	Information about people at increased risk from coronavirus.
COVID-19 rehabilitation service modelling	INQ000081360	2020-08-03	Rehabilitation Service Modelling Resource.
Clinical assessment of COVID-19 in the community (WHC/2020/012)	INQ000048607	2020-08-04	Welsh Health Circular WHC (2020) 012 from the CMO to GPs, 111 and WAST on the clinical assessment of Covid-19 in the community.
Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus (COVID-19)	INQ000081384	2020-08-16	Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus.
Tiger Eye Protector Product – Removal from the Supply Chain in respect of Covid-19 use	INQ000081415	2020-09-03	PPE guidance.
Last Person Standing	INQ000081505	2020-10-01	Welsh Health Circular on GP premises liabilities.
Health and wellbeing support for NHS health boards and trusts workforce (WHC/2020/019)	INQ000412592	30/10/2020	Welsh Health Circular WHC/2020/019on health and wellbeing support for NHS health boards and trusts workforce.

Document Name	Control Number	Document Date	Description
Immediate actions in response to mink-variant SARS-CoV-2 virus in Denmark	INQ000081603	2020-11-09	Guidance from the CMO to the NHS Wales about actions required in response to mink-variant SARS-CoV-2 virus in Denmark.
Hospital visiting during the coronavirus outbreak: guidance	INQ000081643	2020-11-30	Hospital visiting during the coronavirus outbreak guidance.
Christmas advice for people who were shielding	INQ000081669	2020-12-17	Christmas advice for people who were shielding.
COVID-19 Hospital Discharge Service Requirements (Wales): Update to guidance in respect of testing and step-up & step-down care arrangements during the COVID-19 period	INQ000081672	2020-12-17	Hospital discharge service requirements.
Self-isolation: Stay at home guidance for households with possible coronavirus	INQ000081710	21-12-2020	Guidance on managing covid-19 at home
Guidance on protecting people defined on medical grounds as clinically extremely vulnerable from coronavirus (COVID-19) – previously known as 'shielding'	INQ000081717	2020-12-22	Guidance on protecting people defined on medical grounds as clinically extremely vulnerable from coronavirus (COVID-19) - previously known as 'shielding'
Shielding update advice for people in Wales on the shielding patient list from 22 December [Easy read]	INQ000081719	2020-12-22	Shielding update
Therapeutic Anticoagulation (Heparin) in the Management of Severe COVID-19 (SARS-CoV-2 Positive) Patients	INQ000081728	2020-12-23	Therapeutic Anticoagulation (Heparin) in the Management of Severe COVID-19 (SARS-CoV-2 Positive) Patients

Document Name	Control Number	Document Date	Description
Therapeutic anticoagulation (Heparin) in the management of severe COVID - 19 (Sars-Cov-2 positive) patients	INQ000081733	2020-12-23	Information from the Chief Pharmaceutical Officer on Therapeutic Anticoagulation (Heparin) in the Management of Severe COVID-19 (SARS-CoV-2 Positive) Patients
CMO alert: updated guidance for Wales - investigation and management of sars-cov-2 virus new variants of concern	INQ000081734	2020-12-29	CMO alert on new variants of concern.
Operational guide for the transition of healthcare environments in preparation for Autumn/Winter 2021/22 incorporating COVID-19 measures.	INQ000081741	2021-01-01	Operational guide for the transition of healthcare environments in preparation for autumn winter.
Supporting the healthcare science workforce throughout the second COVID-19 wave [Letter]	INQ000081746	2021-01-06	Supporting the healthcare science workforce throughout the second covid 19 wave
Supporting doctors throughout the COVID-19 pandemic	INQ000081775	2021-01-13	Information from the CMO on supporting doctors throughout the Covid-19 pandemic.
SUPPORTING DOCTORS IN THE EVENT OF A COVID19 EPIDEMIC IN THE UK	INQ000081772	2021-01-13	Information from the CMO on supporting doctors throughout the Covid-19 pandemic.
Supporting doctors throughout the second COVID-19 wave	INQ000081773	2021-01-13	Information from the CMO on supporting doctors throughout the Covid-19 pandemic.
Supporting doctors throughout the COVID-19 pandemic	INQ000081774	2021-01-13	Information from the CMO on supporting doctors throughout the Covid-19 pandemic.
Guidance on protecting people defined on medical grounds as clinically extremely vulnerable from coronavirus	INQ000081809	2021-01-27	Guidance on shielding.

Document Name	Control Number	Document Date	Description
(COVID-19) – Previously known as 'shielding'			
Interleukin-6 inhibitors (tocilizumab and sarilumab) for critically ill patients with Covid-19 pneumonia (adults)	INQ000081812	2021-02-01	Interleukin-6 Inhibitors (Tocilizumab And Sarilumab) For Critically Ill Patients With Covid-19 Pneumonia (Adults) from CMO.
Guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from coronavirus Covid-19	INQ000081824	2021-02-03	Guidance on shielding.
Guidance on protecting people defined on medical grounds as clinically extremely vulnerable from coronavirus (COVID-19): previously known as 'shielding'	INQ000081836	2021-02-05	Guidance on shielding.
All Wales COVID-19 workforce risk assessment tool guidance for managers and staff: 5 February 2021 update:	INQ000081828	2021-02-05	Workforce risk assessment tool guidance for managers and staff, including healthcare workers.
COVID – 19 Therapeutic Alert Interleukin-6 inhibitors (tocilizumab or sarilumab) for hospitalised patients with COVID-19 pneumonia (adults)	INQ000081856	2021-02-19	Therapeutic alert from CMO
Interleukin-6 inhibitors (tocilizumab or sarilumab) for	INQ000081865	2021-02-19	Interleukin-6 inhibitors (tocilizumab or sarilumab) for hospitalised patients with Covid-19 pneumonia (adults)

Document Name	Control Number	Document Date	Description
hospitalised patients with Covid-19 pneumonia (adults)			
Interleukin-6 inhibitors (tocilizumab or sarilumab) for critically ill patients with COVID-19 pneumonia (adults)	INQ000081867	2021-02-21	CMO alert
Principles for Critical Care Mutual Aid during the Covid-19 Pandemic ENGLISH	INQ000081877	2021-02-26	Principles for Critical Care Mutual Aid during the Covid-19 Pandemic
Operational Checklist - critical care capacity - final version	INQ000081879	2021-02-26	Operational checklist re critical care capacity
Mental health guidance ENGLISH	INQ000081902	2021-03-16	Mental health guidance
National clinical framework: a learning health and care system	INQ000081910	2021-03-22	National clinical framework
All Wales COVID-19 workforce risk assessment tool guidance for managers and staff: 26 March 2021 update:	INQ000081921	2021-03-26	All Wales COVID - 19 workforce risk assessment tool guidance for managers and staff, including healthcare workers
All Wales COVID-19 workforce risk assessment tool: guidance for managers and staff	INQ000082068	2021-06-01	COVID - 19 workforce risk assessment tool guidance for managers and staff, including healthcare workers
Guidance on protecting people defined on medical grounds as clinically extremely vulnerable from coronavirus (COVID-19) – previously known as 'shielding'	INQ000082105	2021-06-11	Shielding guidance
Hospital visiting during the	INQ000082115	2021-06-18	Hospital visiting guidance

Document Name	Control Number	Document Date	Description
coronavirus outbreak guidance			
Hospital visiting during the pandemic: Supplementary statement June 2021	INQ000082117	2021-06-18	Hospital visiting guidance
Getting support for recovery from COVID-19 (long COVID)	INQ000082133	2021-06-28	Long covid guidance
Social care recovery framework: COVID-19	INQ000082184	2021-07-21	Guidance on future of health services
National enhanced service: Provision of near-patient testing	INQ000082185	2021-07-21	Enhanced services
National enhanced service: Specialised care of patients with depression	INQ000082186	2021-07-21	Enhanced services
Shielding update letter: Advice for people who are clinically extremely vulnerable as COVID-19 rules are relaxed – from Dr Frank Atherton July 2021 [Easy Read]	INQ000082194	2021-07-27	Shielding letter
COVID-19 contacts: Guidance for health and social care staff	INQ000082235	2021-08-11	Guidance for health and social care who have come into direct contact with patients or service users with covid-19
COVID-19 contacts: guidance for health a nd social care staff	INQ000082239	2021-08-11	Guidance for health and social care who have come into direct contact with patients or service users with covid-19
Third primary dose of Covid-19 vaccine for severely immunocompromised patients	INQ000082285	2021-09-02	CMO alert on Third Primary dose of Covid-19 Vaccine for Severely Immunocompromised patients ENGLISH
Personal protective equipment and heat: risk of heat stress	INQ000082307	2021-09-20	CMO alert on PPE and heat and risk of heat stress
Dental management o f patients in Wales du	INQ000082327	2021-09-30	Dental management of patients in Wales during covid-19 pandemic recovery

Document Name	Control Number	Document Date	Description
ring C-19 pandemic recovery			
Self-isolation	INQ000082338	05-10-2021	Guidance on managing covid-19 at home
Children and young people with higher clinical risk and clinically extremely vulnerable adults: guidance for education settings	INQ000082370	2021-10-12	Guidance on children and young people with higher clinical risk in the education setting
Self-isolation	INQ000082387	26-10-2021`	Guidance on managing covid-19 at home
COVID-19 hospital discharge service requirements (Wales): update to guidance in respect of testing and step-up & step-down care arrangements during the COVID-19 period	INQ000082432	2021-11-25	Hospital discharge service requirements
Dental management of patients in Wales during C - 19 pandemic recovery	INQ000082445	2021-12-01	Dental management of patients in Wales during the covid-19 pandemic recovery
Children and young people with higher clinical risk and clinically extremely vulnerable adults: guidance for education settings	INQ000082538	2021-12-31	Guidance on children and young people with higher clinical risk in the education setting
Staff working with children and young people with higher clinical risk: Tailored Testing Scheme	INQ000082561	2022-01-06	Children and young people with higher clinical risk testing scheme
Self-isolation	INQ000082559	06-01-2022	Guidance on managing covid-19 at home
Hospital visiting during the coronavirus pandemic: Supplementary statement Jun 2021	INQ000082576	2022-01-10	Hospital visiting guidance

Document Name	Control Number	Document Date	Description
COVID-19 contacts: guidance for health and social care staff	INQ000082580	2022-01-12	Guidance for health staff on coming into contact with persons with covid-19
COVID-19 Hospital Discharge Service Requirements	INQ000082602	2022-01-28	Hospital discharge service requirements
Self-isolation	INQ000082672	18-02-2022	Guidance on managing covid-19 at home
Staff working with children and young people with higher clinical risk: tailored testing scheme	INQ000082683	2022-02-21	Children and young people with higher clinical risk testing scheme
COVID-19 workforce risk assessment tool: guidance	INQ000082689	2022-02-23	Workforce risk assessment tool guidance for managers and staff, including healthcare workers
Social care staff responsibilities and COVID-19: guidance	INQ000082731	2022-03-25	Guidelines for health and social care workers
Continuing NHS Healthcare information booklet for individuals, families and carers: What is continuing NHS healthcare? Who should get it? How is it organised?	INQ000082763	2022-04-01	Continuing NHS healthcare information booklet
Self-isolation: guidance for people with Covid-19 and their contacts	INQ000082768	01-04-2022	Guidance on managing covid-19 at home
Prioritisation of COVID - 19 patient episodes by NHS Wales Clinical Coding Departments	INQ000082769	2022-04-04	Prioritisation of Covid-19 patient episodes by NHS Wales coding departments
Children and young people with higher clinical risk and clinically extremely vulnerable adults: guidance for education settings	INQ000082772	2022-04-12	Children and young people with higher clinical risk guidance
Staff working with Children and young people with higher	INQ000082775	2022-04-12	Children and young people with higher clinical risk testing scheme

Document Name	Control Number	Document Date	Description
clinical risk: tailored Testing Scheme			
Self-isolation: guidance for people with covid-19 and their contacts	INQ000082789	19-04-2022	Guidance on managing covid-19 at home
Dental management for respiratory transmitted illnesses (Including COVID-19) in Wales	INQ000082798	2022-05-01	Dental management for respiratory transmitted illnesses (Including COVID-19) in Wales
Self-isolation: guidance for people with Covid-19 and their contacts	INQ000082804	04-05-2022	Guidance on managing covid-19 at home
Hospital visiting during the coronavirus outbreak: guidance	INQ000082810	2022-05-09	Hospital visiting guidance
COVID-19: guidance for student nurses	INQ000082818	2022-05-18	Guidance for student nurses