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UK COVID-19 INQUIRY

WITNESS STATEMENT OF JUDITH PAGET

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I, Judith Paget 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 dated 6 November 2023 and referenced M3-WGO-02.

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. My response to the Inquiry's request for evidence made under Rule 9 of the Inquiry Rules 2006, referenced M3-WGO-02, relates to specific operational information about how the NHS in Wales responded to the pandemic and will cover the period from the 1 March 2020 and 28 June 2022 (which I will refer to in this statement as "the relevant period").

4. This statement is given in my capacity as Chief Executive Officer of NHS Wales and Director General of the Health, Social Care and Early Years Group. During the relevant period, the Health, Social Care and Early Years Group was known as the Health and Social Services Group and therefore I will continue to refer to it as the Health and Social Services Group for the purposes of this statement.

5. In order to fully address the Inquiry's request for evidence on the matters outlined this statement, which includes matters which pre-date my appointment as Chief Executive Officer of NHS Wales and Director General of the Health and Social Services Group, I have needed to obtain information from senior members of the civil service 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

6. I hold a Diploma in Management Studies and a Master of Science, Primary Care Policy and Management from the Health Services Management Centre at the University of Birmingham.

7. I have worked for 43 years within the NHS in Wales and a copy of my CV is attached as exhibit **JPM3WGO02/01 - INQ000239577**.

8. I began as a Clerical Officer for Community Health Services in South Gwent in 1980, after which I held a number of management roles in hospitals and Health Authorities. I joined the Aneurin Bevan University Health Board in October 2009 as Director of Planning and Operations/Deputy Chief Executive, in September 2012 I was appointed as Chief Operating Officer/Deputy Chief Executive and in June 2014 I was promoted to Chief Executive.

9. As the Chief Executive at Aneurin Bevan University Health Board I was responsible for managing all aspects of the Health Board's activities, including improving population health and patient services, performance and strategic partnership working, all aspects of governance and staff leadership. Providing advice to the Health Board on all aspects of Board business and, as Accountable Officer, specifically on matters relating to probity, regularity and administration. I led Aneurin Bevan University Health Board's response to the Covid-19 pandemic until I left in October 2021.

10. I was appointed to the role of Interim Chief Executive of the NHS in Wales and Director General of the Health and Social Services Group in November 2021. I was made permanent in this role in June 2023.

11. The role of Chief Executive of NHS Wales is not a statutory role, but 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 the NHS in Wales.

Background

Organisational Structure of the NHS in Wales

12. The organisational and governmental structure of the NHS in Wales is primarily set out in the National Health Service (Wales) Act 2006 ("the 2006 Act"). 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. The 2006 Act consolidated, in relation to Wales, the provisions of the National Health Service Act 1977 and

associated legislation in order to set out in one statute the distinct structure of the Welsh NHS. In England, the National Health Service Act 2006 provides the legislative structure for the NHS in England. There are many differences between the structures and governance of the NHS in England and Wales, especially with regards to the health service bodies in operation in Wales. For example, there are three principal kinds of NHS bodies under the 2006 Act: Local Health Boards, NHS Trusts ("Trusts") and Special Health Authorities (collectively "the NHS bodies"). In England however there are also NHS Foundation Trusts and Integrated Care Boards among other bodies such as Public Health England and NHS England. I have set out below detail of how the three principal kinds of bodies in Wales are organised and operate to deliver healthcare services in Wales.

Local Health Boards in Wales

13. 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.

14. There are currently seven Local Health Boards in Wales[1]:

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

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

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

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

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

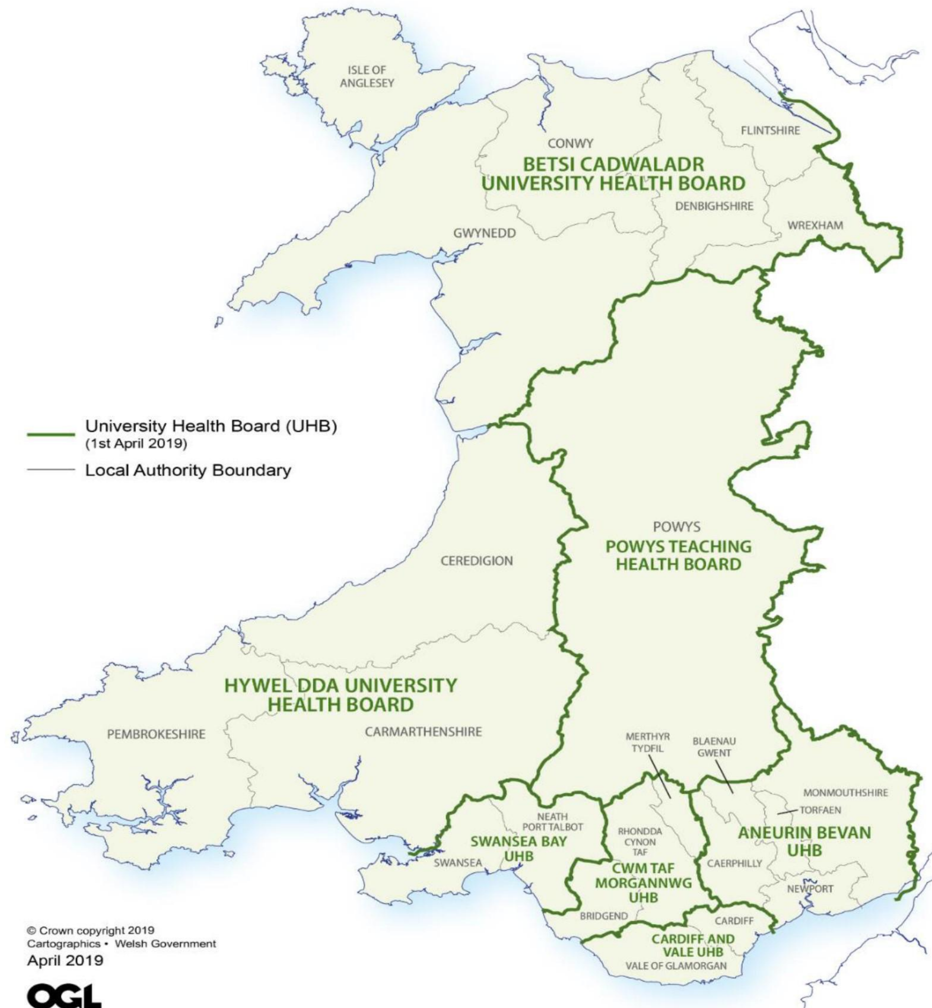
    f) Powys Teaching Local Health Board (covering Powys) (operating as Powys Teaching Health Board)

[1] The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009, No. 778 (W.66)

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

15. A map illustrating the geographical areas of each Local Health Board in Wales is set out below:

Figure 1: Map illustrating the geographical areas of each Local Health Board in Wales



16. In accordance with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) the members of a Local Health Board consist of:

    a) Eleven non-officer members (known as independent members) that include a chair, vice-chair (who has specific responsibility for overseeing the Local Health Board's performance in the planning, delivery and evaluation of primary care, community and mental health services[2]), a local authority member, a voluntary organisation member, a trade union member, and a person who holds a health-related post in a university, and any associate members[3]. The chair, vice chair and non-officer members are appointed by the Welsh Ministers.

    b) Nine officer members (representative of different healthcare professions and responsibilities) appointed by the Board.

17. The Welsh Ministers may also appoint up to three associate members, while the Local Health Board may appoint one associate member (with the written consent of the Welsh Ministers); these associate members do not have any voting rights.

18. The Local Health Board both appoints, and has responsibility for the performance of, the officer members. The officer members consist of the following positions in the Local Health Board:

    a) a chief officer (the Chief Executive);

    b) a medical officer;

    c) a finance officer;

    d) a nurse officer;

    e) an officer who has responsibility for provision of the following—

        i. primary care services;

        ii. community health services; and

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[2] This specific responsibility is outlined in the Model Standing Orders for Local Health Boards as issued by the Welsh Ministers

[3] Regulations 3 and 4 of SI 2009/779

iii. mental health services.

f) an officer who has responsibility for workforce and organisational development;

g) an officer who has responsibility for public health;

h) an officer who has responsibility for the strategic and operational planning of the provision of health services;

i) an officer who has responsibility for therapies and health science.

19. A list of the Local Health Board chief officers and chairs between 2020 – 2022 is provided below:

Table 1: Table listing all the Local Health Board chief officers and chairs between 2020 - 2022

Local Health Board	**Current Chair**	**Chair at start of pandemic**	**Current Chief Executive**	**Chief Exec at start of pandemic**
Aneurin Bevan University	Ann Lloyd CBE (since June 2017)	Current	Nicola Prygodzicz (since 5 September 2022)	Judith Paget (2014 – 31 October 2021) Glyn Jones *Interim* (1 November 2021 - 4 September 2022)
Betsi Cadwaladr University	Dyfed Edwards (since February 2023)	Mark Polin (2018-2023)	Carol Shillabeer *Interim* (since 3 May 2023)	Simon Dean *Interim* (Feb 2020 – 31 August 2020) Gill Harris *Interim* (1 Sep

				2020 – 31 December 2020) Jo Whitehead (Jan 2021 – November 2022) Gill Harris *Interim* (November 2022 – May 2023)
Cardiff & Vale University	Charles Janczewski (*Interim* since 6 August 2019 appointed Chair June 2020)	Current	Suzanne Rankin (since 1 February 2022)	Professor Stuart Walker *Interim* (1 October 2022 – 31 January 2022) Len Richards (2017 – 30 September 2021)
Cwm Taf Morgannwg University	Jonathan Morgan (since April 2023) Emrys Elias *Interim* (1 October 2021- March 2023)	Professor Marcus Longley (October 2017 – 30 September 2021)	Paul Mears (since September 2020)	Sharon Hopkins *Interim* (June 2019 – August 2020)

Hywel Dda University	Dr Neil Rhys Wooding (June 2024) Judith Hardisty *Interim* (October 2023 – May 2024)	Maria Battle (August 2019 – October 2023)	Phil Kloer *Interim* (February 2024)	Steve Moore (January 2015 – February 2024)
Powys Teaching	Carl Cooper (since October 2022)	Vivienne Harpwood (2014 – 2022)	Hayley Thomas (*Interim* since 3 May 2023, appointed February 2024))	Carol Shillabeer (March 2015 to 1 May 2023)
Swansea Bay University	Jan Williams (1 June 2024) Emma Wollett (April 2020 – 31 May 2024)	Emma Wollett *Interim* (July 2019 – April 2020)	Richard Evans (*Interim* since August 2023)	Tracy Myhill (2018 – 31 December 2020) Mark Hackett (1 January 2021 – August 2023)

20. All independent members may be appointed for a period of no longer than four years (other than associate members appointed by Local Health Boards, who may be appointed for a period of no longer than one year). Members may be reappointed at the expiry of a period of appointment but cannot hold office for more than eight years (four years in the case of associate members appointed by the Local Health Board).

21. The principal functions of Health Boards are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511), which are regulations made by the Welsh Ministers in exercise of their powers under section 12 of the 2006 Act.

22. The Welsh Ministers delegate to Local Health Boards functions under the 2006 Act as well as under six other statutes[4]. These 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 Boards 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.

23. 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 planning, securing and delivering all healthcare services for their resident population.

NHS Trusts in Wales

24. 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 and Velindre NHS Trust which continued in existence.

25. Public Health Wales NHS Trust was established on 1 October 2009 as a new unified Public Health organisation[5]. The functions of Public Health Wales 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

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

[5] Public Health Wales National Health Service Trust (Establishment) Order 2009/2058

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.

26. 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.

27. Since 1 April 2023, Public Health Wales has hosted the NHS Executive which brings together activities and functions that already existed across the NHS in Wales, namely the Delivery Unit, the Finance Delivery Unit, Improvement Cymru and Health Collaborative. The purpose of the NHS Executive is to drive improvements in the quality and safety of care to achieve better, fairer healthcare outcomes for the people of Wales. To achieve this, under the direction of the Welsh Government, its role is to work on behalf of the Welsh Government enabling and supporting the NHS in Wales to transform clinical services in line with the overall strategic direction and national priorities and standards set by the Welsh Ministers. Underpinned by clinical networks and national programmes as key mechanisms to support improvement, change and delivery, its core functions include:

a) Ensuring that robust assurance processes and mechanisms are in place to hold NHS Wales organisations to account for meeting expectations and outcomes set by the Welsh Government.

b) Ensuring financial sustainability and delivery, alongside maximising the impact and use of health and social care spending in Wales.

c) Delivering ministerial directions and priorities via the National Clinical Framework, supported by strategic clinical and implementation networks and programmes.

d) Translating the policy direction and standards set by Welsh Government into action that improves the quality and safety of healthcare in Wales.

28. The NHS Executive is not a decision-making body, the legislative framework and the responsibilities of individual NHS organisations are unchanged. The Welsh Ministers continue to set priorities, targets and outcome measures for the NHS in Wales and the NHS Executive assists in overseeing and supporting the delivery of those priorities in order to improve quality, safety, performance and health outcomes. The NHS Executive does not have any direct role or function in relation to public health matters, nor does it have responsibility for the provision of medical services or treatment. The Executive Senior Leadership Team within the NHS Executive is ultimately accountable to the Chief Executive of the NHS Wales.

29. The NHS Executive did not play any role in relation to the response of the healthcare system in Wales to the Covid-19 pandemic because it has only been operational since 1 April 2023. However, the experiences and actions during the Covid-19 pandemic have informed the model for support and coordination the NHS Executive will provide. For example, a decision was taken as part of the implementation programme to develop an emergency preparedness function within the NHS Executive in order to provide a national focus for coordination in the NHS in Wales emergency planning and contingency arrangements including monitoring and assurance of emergency preparedness. Accordingly, the NHS Executive would have a role in future emergencies.

30. Welsh Ambulance Services NHS Trust was established pre-devolution on the 1 April 1998[6], with the management of NHS Direct Wales being transferred to Welsh Ambulance Services NHS Trust in April 2007. Welsh Ambulance Services NHS Trust, as the sole national provider of 999 Emergency Medical Services 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 ("Non-Emergency Patient Transport Service").

31. Velindre University NHS Trust was established on 1 April 1994[7] and at that time was a single speciality trust providing only cancer services. Over the years, the Trust has significantly evolved and expanded. The main function of Velindre University NHS Trust is to provide all-Wales and regional clinical health services to the NHS and the people of Wales. Velindre University NHS Trust consists of two clinical divisions: Velindre Cancer Centre and the Welsh Blood Service. The latter works with its UK

[6] The Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998. S.I. 1998/678
[7] Velindre National Health Service Trust (Establishment) Order 1993/2838 (as amended)

counterparts both formally and informally to ensure the safety of the blood supply chain.

32. Velindre University NHS Trust also hosts NHS Wales Shared Services Partnership, and until 1 April 2021 Velindre hosted NHS Wales Informatic Services. On 1 April 2021 NHS Wales Informatic Service's functions were transferred to Digital Health and Care Wales, a new Special Health Authority. Hosted organisations have their own Board or committee where more detailed discussions, review and approval of strategy and performance takes place. Velindre University NHS Trust is accountable for the statutory, legal and compliance framework. Further information about the NHS Wales Shared Services Partnership and NHS Wales Information Services is provided below.

33. Both Welsh Ambulance Services NHS Trust and Velindre University NHS Trust membership and procedures are contained in the NHS Trusts (Membership and Procedure) Regulations 1990[8]. Public Health Wales has separate provision in the Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009[9]. The members of NHS Trusts in Wales consist of:

    a) A chair

    b) A vice-chair[10]

    c) No more than six[11] non-executive directors, excluding the chair and vice chair

    d) No more than six[12] executive directors, which includes the roles of:

        i. The chief officer

        ii. The chief finance officer

34. In the case of Velindre University NHS Trust, the executive directors must also include a medical or dental practitioner and a nurse or midwife and one of the non-executive directors must be appointed from Cardiff University.

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[8] National Health Service Trusts (Membership and Procedure) Regulations 1990 S.I. 1190/2024 (as amended)

[9] The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009. S.I. 2009 as amended.

[10] The Health and Social Care (Quality and Engagement) (Wales) Act 2020 section 24 came into force on the 8 March 2022 to make statutory provision to enable the Welsh Ministers, if they consider it appropriate, to appoint a vice-chair to the board of an NHS Trust.

[11] In the period 12th April 2010 to 31st March 2022 (the majority of the relevant timeframe of the Inquiry) it was no more than 7 non-executive directors, and 5 executive directors.

[12] National Health Service Trusts (Membership and Procedure) Regulations 1990 S.I. 1190/2024 (as amended).

35. In the case of Public Health Wales, the non-executive directors include:

a) A person who holds a health-related post in a university

b) A person with experience of local authorities in Wales

c) A person who is an employee or member of a voluntary sector organisation with experience of such organisations in Wales.

36. The non-executive members are appointed by the Welsh Ministers. The chief officer is appointed by a committee of the chair, vice-chair and non-executive directors of the Trust. In the case of the other executive directors, appointment is by the same committee with the addition of the chief officer.

37. A list of the NHS Trust chief officers and chairs between 2020 – 2022 is provided below:

Table 2: Table listing all the NHS Trust chief officers and chairs between 2020 - 2022

NHS Wales Trusts	Current Chair	Chair at start of pandemic	Current Chief Executive	Chief Exec at start of pandemic
Public Health Wales	Jan Williams OBE (since September 2017 until 31 May 2024)	Current	Dr Tracey Cooper (since June 2014)	Current
Velindre	Donna Mead (since May 2018)	Current	Steve Ham (since approx. 2018)	Current
Welsh Ambulance Services	Colin Dennis (since October 2022)	Martin Woodford (since 2019)	Jason Killens (since September 2018)	Current

Special Health Authorities in Wales

38. There are two Welsh Special Health Authorities: Health Education and Improvement Wales and Digital Health and Care Wales.

39. Health Education and Improvement Wales was established in 2018[13] 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

40. Health Education and Improvement Wales consists of—

    a) a chair;

    b) not more than 6 other members who are not officers of Health Education and Improvement Wales in addition to the chair; and

    c) not more than 5 other members who are officers of Health Education and Improvement Wales, including the office of chief executive.

41. The chair of Health Education and Improvement Wales is appointed by the Welsh Ministers as are up to 6 other members in addition to the chair. The chief executive is appointed by the non-officer members and the other officer members by the chief executive and non-officer members together.

42. Digital Health and Care Wales was established in 2020[14] and became operational in 2021. Digital Health and Care Wales 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;

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[13] Health Education and Improvement Wales (Establishment and Constitution) Order 2017/913

[14] Digital Health and Care Wales (Establishment and Membership) Order 2020/1451

d) supporting bodies and persons identified in directions given by the Welsh Ministers to Digital Health and Care Wales 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.

43. The membership of Digital Health and Care Wales consists of—

a) a chair;

b) a vice-chair;

c) not more than 5 members who are not officers of Digital Health and Care Wales in addition to the chair and vice-chair;

d) not more than 5 members who are officers of Digital Health and Care Wales which must include:

i. a chief officer;

ii. a finance officer;

iii. a clinical officer;

e) not more than 3 associate members.

44. The chair, vice-chair and up to 5 other non-officer members of Digital Health and Care Wales are appointed by the Welsh Ministers. The chief officer is appointed by the non-officer members and all other officer members by the chief officer and non-officer members. Associate members are appointed by the Welsh Ministers or by Digital Health and Care Wales with the Welsh Ministers' consent.

45. There are also two joint Special Health Authorities operating on an England and Wales basis: the NHS Business Services Authority and NHS Blood and Transplant.

46. NHS Business Services Authority[15] and NHS Blood and Transplant[16] are established jointly by the Secretary of State and the Welsh Ministers. As these are joint Special

[15] The NHS Business Services Authority (Awdurdod Gwasanaethau Busnes y GIG) (Establishment and Constitution) Order 2005

[16] The NHS Blood and Transplant (Gwaed a Thrawsblaniadau'r GIG) (Establishment and Constitution) Order 2005

Health Authorities the Welsh Ministers may direct the NHS Business Services Authority or NHS Blood and Transplant 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.

47. A list of the Special Health Authority chief officers and chairs between 2020 – 2022 is provided below:

Table 3: Table listing all the Special Health Authority chief officers and chairs between 2020 - 2022

Special Health Authorities	**Current Chair**	**Chair at start of pandemic**	**Current Chief Executive**	**Chief Exec at start of pandemic**
Digital Health and Care Wales	Simon Jones (since October 2021)	Bob Hudson 2020 – 2021 (DHCW established in 2021)	Helen Thomas (since 2021)	(DHCW established in 2021)
Health Education & Improvement Wales (HEIW)	Dr Chris Jones CBE (since October 2018)	Current	Alex Howells (since February 2018)	Current

Legal relationship with the Welsh Government

48. Healthcare has been a devolved function since 1999. The function was initially carried out by the National Assembly for Wales until 2006, when it was transferred to the Welsh Ministers by section 162 of, and paragraph 30 of Schedule 11 to, the Government of Wales Act 2006.

49. The Welsh Ministers (served by the Welsh Government's Health and Social Services Group) are responsible under the 2006 Act for the promotion and provision of a comprehensive health service in Wales in accordance with the 2006 Act. In addition, the Welsh Ministers must provide certain services, such as hospital accommodation and services or facilities for diagnosis and treatment of illness. The Welsh Ministers

have a broad range of powers that they may exercise in relation to the NHS in Wales, this includes the power to direct Local Health Boards, Trusts and Special Health Authorities to exercise their functions in relation to the health service in Wales. The Welsh Ministers also have powers under the 2006 Act to make appointments to NHS bodies' boards, change their functions, abolish them and exercise powers of intervention.

50. The Welsh Government, through the Minister for Health and Social Services, is responsible for setting policy and standards to promote high quality, safe services based on population health need.

51. The Minister for Health and Social Services is responsible for the NHS in Wales and all aspects of public health and health protection. The Welsh Government and its Ministers are not responsible for operational decision making within the NHS in Wales. Operational decisions are made by the NHS bodies described above. Under the 2006 Act the Welsh Ministers give directions and make regulations with respect to the exercise of those NHS bodies discharging delegated functions. In addition to statutory instruments, Welsh Ministers may issue Guidance and instructions on a wide range of issues in the form of Welsh Health Circulars (previously referred to as Ministerial Letters).

52. 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.[17] 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.

53. The Welsh Government's Health and Social Services Group may also issue information by way of Welsh Health Circular 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. Furthermore, all chief executive officers of NHS bodies are issued an Accountable

[17] 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.

Officer letter on their appointment setting out their specific responsibilities as accountable officers for their organisations and their accountability to the Chief Executive of NHS Wales on those issues.

Leadership of the NHS in Wales

Chief Executives and Chairs in the NHS in Wales

54. Each body in the NHS in Wales has a Chief Executive and Board which is responsible for ensuring appropriate governance arrangements are in place to maintain effective operation and delivery of health services to the people of Wales.

55. 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.

56. 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.

57. In particular, Part 2 of those Regulations make provision:

    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).

58. 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.

59. For local arrangements the Board provides direct leadership. The role of leading the broader NHS in Wales however ultimately falls to the Welsh Ministers who receive policy advice from the Welsh Government's Health and Social Services Group as led the Director General of the Health and Social Services Group, the role I currently hold.

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

60. The Director General of the Health and Social Services Group holds a combined role as Director General and a role referred to as the "Chief Executive NHS Wales". Prior to my appointment, Dr Andrew Goodall held the position of the Director General of the Health and Social Services Group and Chief Executive NHS Wales from June 2014 to November 2021. Dr Andrew Goodall has explained the nature and duties of the role in the corporate statement of the Health and Social Services Group (reference: M3-WGO-01) at paragraphs 40-46.

61. The Chief Medical Officer, the Deputy Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer, Chief Midwifery Officer, Chief Scientific Adviser for Health, Chief Allied Health Professional Officer, Chief Optometric Officer and Chief Dental Officer are all members of the Health and Social Services Group and also provide professional leadership for the NHS in Wales.

Chief Medical Officer

62. 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. See further information at paragraphs 56-57 of the corporate statement of the Health and Social Services Group (reference: M3-WGO-01).

Deputy Chief Medical Officer

63. The Deputy Chief Medical Officer holds significant direct policy responsibility for a wide range of clinical service areas, many of which were directly relevant to the pandemic response. This includes: healthcare quality policy; patient safety; quality improvement; patient experience; blood policy; healthcare acquired infections; antimicrobial resistance; critical care; respiratory health; cardiac health; diabetes

care; cancer care; vascular surgery; organ donation and transplantation; renal medicine; liver disease; neurological conditions; stroke care; end of life care; frailty; patient consent; medical devices (safety, registration and information); medical device recording system; medical examiners and death certification; women's health' children's health and neonatal care. Early in the pandemic, the work of the Deputy Chief Medical Officer was mainly focused on the NHS response and participated in the UK Senior Clinicians Group and Chief Medical Officer discussions. Although the Deputy Chief Medical Officer was not closely involved in the public health response in the initial months of the pandemic, the Deputy Chief Medical Officer became gradually more involved particularly in terms of deputising for the Chief Medical Officer for Wales.

Chief Nursing Officer

64. 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 of 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. See further information at paragraphs 58 - 59 of the corporate statement of the Health and Social Services Group (reference: M3-WGO-01).

Chief Pharmaceutical Officer

65. The Chief Pharmaceutical Officer is the Welsh Government's principal advisor on all aspects of pharmacy practice, prescribing and medicines related issues. The Chief Pharmaceutical Officer is expected to lead strategic development and provide exemplary, impartial, and authoritative advice across Welsh Government and the NHS in 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. See further information at paragraphs 60 - 61 of the corporate statement of the Health and Social Services Group (reference: M3-WGO-01).

Chief Midwifery Officer

66. The Chief Midwifery Officer is the Welsh Government's principal advisor and policy lead on all aspects of maternity and neonatal services. Prior to May 2022 this role was known as the Nursing Officer for Maternity and Early Years with policy and professional lead role covering maternity, health visiting and school nursing. Prior to May 2022, neonatal services was led by the Deputy Chief Medical Officer.

Chief Scientific Advisor for Health

67. The Chief Scientific Advisor for Health is responsible for 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's policies. See further information at paragraphs 62 – 63 of the corporate statement of the Health and Social Services Group (reference: M3-WGO-01).

Chief Allied Health Professional Officer

68. The Chief Allied Health Professions Advisor is the Welsh Government's principal advisor on all aspects of the professional practice of the 13 Allied Health Professions regulated by the Health and Care Professions Council. They provide advice and professional insight in all aspects of Allied Health Professions practice across the whole health and care system, including mental and physical health, primary community and social care as well as in hospital care; and with people from birth to end of life. They work closely with the Head of Rehabilitation Policy and lead the strategic vision and direction for the Allied Health Professions Transformation in line with the Allied Health Professions Framework for Wales.

Chief Optometric Officer

69. The Chief Optometric Officer is the Welsh Government's principal advisor on all aspects of eye health care, specialising in optometry practice. They lead on strategic development and provide exemplary, impartial, and authoritative advice across the Welsh Government, the NHS in Wales and the ophthalmic profession, in a range of areas regarding eye health and social care, including regulation, education, training, standards and performance and developing policy and legislation. The Chief Optometric Officer works closely with all eye care stakeholders including Llais, the

third sector and voluntary sector, to implement the Government's objectives to improve the health and well-being of citizens across Wales.

Chief Dental Officer

70. The Chief Dental Officer is the Welsh Government's principal advisor on all aspects of dentistry practice and oral health. They lead strategic development and provide exemplary, impartial, and authoritative advice across the Welsh Government and the NHS in Wales. They provide leadership to all dental practitioners and dental care professionals, lead strategic development of dental healthcare services and promotion of improvement of the population ensuring timely access to dental services and implementation of evidence-based standards to achieve, and maintain, high quality dental services. They are also responsible for the monitoring and promoting of dental healthcare services, patient-related outcomes, strategies to address oral health inequalities, oral health regulation, education & training, and performance.

The NHS in Wales working together

71. The 2006 Act provides 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 2006 Act;[18] 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)[19] and they may also be directed by the Welsh Ministers for their functions to be exercised by committees or by a Special Health Authority.

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

NHS Wales Shared Services Partnership

73. Velindre NHS Trust has the function of managing and providing shared services to the health service in Wales. The NHS Wales Shared Services Partnership is the

[18] Section 10 of the NHS (Wales) Act 2006.
[19] Section 13 of the NHS (Wales) Act 2006.

operational name for the Shared Services Committee of Velindre NHS Trust. The NHS Wales Shared Services Partnership 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 NHS Trusts. The Committee has a designated Accountable Officer for Shared Services and through the Committee is accountable to the Welsh Ministers. The Committee produces its own Annual Governance statement.

74. NHS Wales Shared Services Partnership 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 NHS Wales Shared Services Partnership such as health courier services, laundry services, and student award schemes. The NHS Wales Shared Services Partnership delivers a wide range of high quality, professional, technical, and administrative services for and on behalf of the NHS in Wales also working with the wider public services, including the Welsh Government. This organisation is also sometimes referred to as “Shared Services”.

Welsh Health Specialised Services Committee

75. Prior to 1 April 2024, the Welsh Health Specialised Services Committee was a joint committee of the Local Health Boards in Wales and established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The joint committee was 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 Welsh Health Specialised Services Committee 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.

76. Since 1 April 2024, the functions exercised by the Welsh Health Specialised Services Committee are exercised by a new joint committee known as the NHS Wales Joint Commissioning Committee hosted by Cwm Taf University Health Board.

77. Local Health Boards are responsible for those people who are resident in their areas. Whilst the joint committee 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.

Emergency Ambulance Service Committee

78. Prior to 1 April 2024, the Emergency Ambulance Services Committee was a joint committee established on 1 April 2014 which had the responsibility to 'plan and secure emergency ambulance services for the sick and injured'. In December 2015, the Welsh Ministers directed Local Health Boards to be responsible for commissioning Non-Emergency Patient Transport Services via the Emergency Ambulance Services Committee from April 2016.

79. 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 Non-Emergency Patient Transport Service, for Wales. Welsh Ambulance Services NHS Trust, therefore, is responsible for supplying the urgent and emergency medical services, and Non-Emergency Patient Transport Services, based on a robust commissioning framework. The National Collaborative Commissioning Unit is responsible for delivering national commissioning programmes. The National Collaborative Commissioning Unit 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". The National Collaborative Commissioning Unit is established under the organisational arrangements of Emergency Ambulance Service Committee. The Emergency Ambulance Service Committee was hosted by Cwm Taf University Health Board on behalf of Local Health Boards in Wales.

80. Since 1 April 2024, the functions exercised by the Emergency Ambulance Service Committee are exercised by a new joint committee known as the NHS Wales Joint Commissioning Committee hosted by Cwm Taf University Health Board

NHS Delivery Unit

81. 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 during the relevant period by Swansea Bay University Health Board and accountable to the Deputy Chief Executive of the NHS in Wales. The purpose of the NHS Delivery Unit

is to achieve sustainable improvement in the NHS in Wales through a whole system approach to health and care.

82. During the relevant period, the NHS Delivery Unit provided support to the Welsh Government as part of the pandemic response. It did this by providing members of its workforce to support the Welsh Government on its planning and response arrangements by providing operational expertise on a range of policy development matters. Such matters included: identifying the section of the population who would be advised to shield; therapy policy response; revised discharge policy for acute and community hospitals; the implementation and monitoring of the essential services framework; the monitoring of NHS services in order to prepare for recovery of non-Covid related services; the Test, Trace and Protect Programme and the operational delivery coordination of the NHS in Wales in the delivery of the Covid-19 vaccination roll out. The NHS Delivery Unit did not undertake any performance management function and did not provide any direct patient care during the relevant period.

83. Since 1 April 2023, the NHS Delivery Unit forms part of NHS Executive which is hosted by Public Health Wales.

NHS Finance Delivery Unit

84. 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 the NHS in Wales and to respond at pace where organisations are demonstrating evidence of potential financial failure; and accelerate the uptake across the NHS in Wales of best practice in financial management and technical and allocative efficiency. During the relevant period, the Finance Delivery Unit was accountable to the Director of Finance, Health and Social Services Group in the Welsh Government and hosted by Public Health Wales on behalf of the Health and Social Services Group. The annual work programme is agreed and monitored through regular meetings with the Welsh Government.

85. Since 1 April 2023, the NHS Delivery Unit forms part of NHS Executive which is hosted by Public Health Wales.

NHS Wales Health Collaborative

86. 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 the NHS in Wales. Through facilitating engagement, networking and collaboration between the NHS in Wales partners and other stakeholders, the NHS Wales Health Collaborative works to support the improvement of the NHS in Wales' services across organisational boundaries and improve the quality of care for patients. The Collaborative covers a broad range of clinical networks (including the Wales Cancer Network and the Wales Cardiac Network), national programmes and projects, major conditions implementation groups, and support functions. During the relevant period, the NHS Wales Health Collaborative was hosted by Public Health Wales.

87. As part of the pandemic response, the NHS Wales Health Collaborative temporarily redeployed its clinicians to the front line in order to support the Local Health Boards. The NHS Wales Health Collaborative also supported the Welsh Government by providing clinical expertise in relation to maintaining essential services during the pandemic. For example, the Wales Cancer Network (which forms part of the NHS Wales Health Collaborative) developed frameworks which provided detail on maintaining cancer services. A Director of the NHS Wales Health Collaborative also co-chaired the Welsh Government's Essential Services Sub-Group.

88. Since 1 April 2023, NHS Wales Health Collaborative forms part of NHS Executive which is hosted by Public Health Wales.

NHS Wales Informatics Service

89. NHS Wales Informatic Service 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*". NHS Wales Informatic Service delivered these services across NHS Wales as part of Velindre NHS Trust. NHS Wales Informatic Service's functions were transferred to Digital Health and Care Wales when it was established as a Special Health Authority and became operational in 2021. NHS

Wales Informatic Service staff and services were transferred to Digital Health and Care Wales entirely from 1 April 2021.

NHS Wales Improvement Cymru

90. Improvement Cymru is the all-Wales improvement service for the NHS in 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. During the relevant period, it was part of Public Health Wales and was made up of experts in developing, embedding, and delivering system-wide improvements across health and social care. Improvement Cymru works closely with the NHS in Wales to support it to continually improve what it does and how it does it to help create a healthier Wales.

91. During the relevant period, NHS Wales Improvement Cymru provided support to the NHS in Wales including developing and rolling out the testing system, operating the drive through centre and working with the army to establish new testing sites.

92. Since 1 April 2023, NHS Wales Improvement Cymru forms part of NHS Executive which is hosted by Public Health Wales.

Emergency Medical Retrieval and Transfer Service

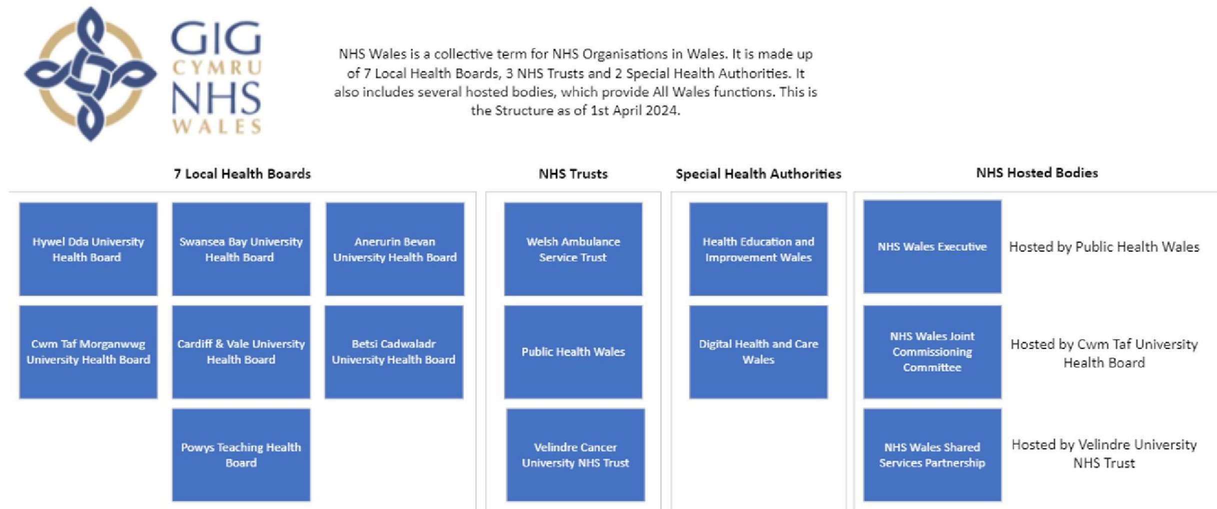
93. The Emergency Medical Retrieval and Transfer Service Cymru is a pre-hospital critical care service in Wales. It is a partnership between Wales Air Ambulance, the Welsh Government and the NHS in Wales.

Structure of the NHS organisations - diagram

94. I have set out below a diagram showing the structure of the NHS organisations in Wales as of 2020 and another as of 1 April 2024.

Figure 2: Diagram showing the structure of NHS organisations in Wales as of 2020

Figure 3: Diagram showing the structure of NHS organisations in Wales as of 1 April 2024



Other bodies relevant to the NHS in Wales

95. In addition to the bodies and organisations referred to earlier in this statement, there are also other bodies which are relevant to the operation of the NHS in Wales:

Regional Partnership Boards

96. Regional Partnership Boards 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 Regional Partnership Boards 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.

97. There are 7 Regional Partnership Boards linked to the Local Health Boards 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 Services Boards

98. The NHS in 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' to improve the well-being of their area by contributing to the achievement of the well-being goals. Public Services Boards are established for each local authority area in Wales with the following being statutory members of each Public Services Board:

a) Local authority

b) Local Health Board

c) Fire and Rescue Authority

d) Natural Resources Wales

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

i. Welsh Ministers
ii. Chief Constables
iii. Police and Crime Commissioner
iv. Relevant Probation Services
v. At least one body representing voluntary organisations.

100. Each Public Services Board must carry out a well-being assessment and publish an annual local well-being plan. The plan sets out how the Board will meet its responsibilities under the Well-being of Future Generations (Wales) Act 2015.

Welsh NHS Confederation

101. The Welsh NHS Confederation is not part of Welsh Government's management structure for the NHS in Wales. It is part of the NHS in Wales' network and collaborative arrangements. For the Inquiry's benefit, 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. 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 Special Health Authorities in Wales and the director of the Welsh NHS Confederation.

Pandemic response functions

102. Prior to 2020 there had been work across the NHS in Wales to plan for a public health emergency, including pandemics. As distinct from NHS England, there is no legally constituted body "NHS Wales". Therefore, the legal obligations and responsibilities of category 1 responders for the purposes of the Civil Contingencies Act 2004 ("CCA 2004") are vested in the Local Health Boards, Public Health Wales and the Welsh Ambulance Services NHS Trust, who are designated as category 1 responders, and as such the respective Chief Executive Officers of those bodies, and not the Welsh Government are accountable for ensuring that emergency and business continuity arrangements are in place.

103. The Chief Executive Officer of each NHS body is expected to ensure that the Board receives regular emergency preparedness reports, at least annually, covering risk assessment, the resilience of emergency and business continuity plans against the risks identified, and the training and exercises undertaken to prepare staff and test response arrangements.

104. Additionally, the Chief Executive must ensure that an Executive Director of the Board is designated to take responsibility for emergency preparedness on behalf of the organisation, and an officer is appointed and adequately resourced to support the Executive Director and Chief Executive in the discharge of these duties. Each organisation has a designated emergency planning lead working full-time on NHS resilience matters. In delivering their responsibilities under the CCA 2004, the NHS in Wales contributes to multi-agency planning at all levels through its participation in the all-Wales planning structure and its engagement with Local Resilience Fora. The devolved function responsibilities in relation to health and other areas such as local government, transport and the environment enables the Welsh Government to play a coordinating role supporting category 1 responders in Wales to work together. For example, the Welsh Government is represented on all four Local Resilience Forums in Wales in an observer capacity. The Chief Executive NHS Wales is also a member of the Joint Emergency Services Group and the Wales Resilience Forum. The UK Government has duties under the CCA 2004 to consult the Welsh Government in relation to changes in regulations which affect bodies who exercise functions in relation to Wales and would also informally update the Welsh Government on matters relating to civil protection. The Welsh Government works with Category 1 responders in developing pan-Wales plans. In developing plans, the Welsh Government is able

to offer advice to Category 1 responders in Wales in terms of consistency with pan-Wales and pan-UK plans.

105. The NHS in Wales also participates in the Wales NHS Emergency Planning Advisors Group with sub-groups being operated to address issues such as mass casualties, pre-hospital response requirements, health countermeasures and Wales NHS training and exercises, all feeding into the multi-agency planning arrangements at all levels. The NHS Wales Training and Exercise Group co-ordinates delivery of NHS Wales training and exercises in support of NHS emergency plans and to address national risks.

Healthcare systems response to the Covid-19 pandemic

106. The Inquiry has asked me for information about the healthcare systems' response to the Covid-19 pandemic. In order to address these questions, I have received support from Professor Chris Jones (Deputy Chief Medical Officer for Wales), Samia Edmonds (Planning Director), Name Redacted (Interim Deputy Director Science Evidence Advice) and Sioned Rees (Interim Director Public Health Protection).

Extent of the Welsh Government's powers and responsibilities in relation to operational decision-making within the NHS in Wales during the relevant period

107. As referred to earlier in this statement, healthcare is a devolved function and, under the 2006 Act, the Welsh Ministers are responsible for the promotion and provision of a comprehensive health service as well as the provision of hospital accommodation and services or facilities for diagnosis and treatment of illness. Whilst health care services are ultimately delivered on behalf of the Welsh Government by Local Health Boards, NHS Trusts and Special Health Authorities, the Welsh Government provides strategic oversight in relation to the delivery of health care services by setting policy and standards to promote high quality, safe services based on population health need. This approach was no different during the Covid-19 pandemic; although operational decision making was undertaken at the local level by individual Local Health Boards and NHS Trusts, the Welsh Government provided strategic oversight and co-ordination in relation to the pandemic response. The Welsh Government's role in that regard is illustrated below.

108. At the start of the pandemic the NHS in Wales was aware of the need to consider how it organised itself, what resources it had and what support from the Welsh

Government it required to meet the forthcoming challenges. The Welsh Government's powers and responsibilities in relation to operational decision-making within the NHS in Wales during the relevant period did not change however there was a gear change in how those powers and responsibilities were utilised during this period.

109. To support initial actions by NHS bodies in Wales, Dr Andrew Goodall, the Chief Executive NHS Wales at the time, put in place a series of regular national Chief Executive telephone calls to share information and take on any strategic issues on behalf of the Chief Executives of the NHS bodies. Each of the Welsh Government executive directors also held regular meetings of their peer group in the NHS to ensure coherence.

110. Operational decision making was still with the Chief Executives of the individual bodies, but the regular meetings meant that there was, during this time, a stronger central voice (in the form of Dr Andrew Goodall) and more collective discussions and ultimately decision making at a national level.

111. Early in March 2020, the all-Wales Board Secretaries met with the Welsh Government's Deputy Director, Mental Health, NHS Governance and Corporate Services. Due to modelling which indicated that the pandemic was expected to escalate over the coming weeks and months, the NHS in Wales wanted clarity on how to use the NHS governance arrangements to enable the continued appropriate functioning of the NHS in Wales but in such a way to ensure there was agile decision making and reduced bureaucracy given the expected demands on the NHS' resources.

112. During the early stages of the pandemic, the Board Secretaries proposed several governance principles to use as a framework against which to assess governance decisions. These principles are detailed in exhibit **JPM3WGO02/02- INQ000182552** but in summary comprised of the following list of key principles to help focus the NHS in Wales's consideration of governance issues:

a) Public interest and patient safety

b) Staff well-being and deployment

c) Good governance and risk management

d) Delegation and escalation

e) Departures

f) One Wales

g) Communication and transparency

113. The Board Secretaries proposed several changes to the way in which the NHS in Wales operated during this period including arrangements for Boards and their membership, decision making and schemes of delegation and end of year reporting. It also included a proposal to stand down the majority of routine NHS Wales committee and partnership committee meetings except for the Quality and Safety Committees and the Audit Committees.

114. The Director of Mental Health, Vulnerable Groups and NHS Governance replied to the NHS Wales Board Secretaries noting that all the proposals for streamlining the NHS Governance arrangements were broadly agreed and required no further action from the Welsh Government to facilitate them. This response is exhibited at **JPM3WGO02/03 - INQ000253565**. The only exception was the request to amend the tenure of office for NHS Wales Board members and the requirement to hold an Annual General Meeting on a certain date.

115. On the first issue, each NHS Body has certain membership requirements set out in legislation. Many Local Health Boards and NHS Trusts needed to undertake recruitment of independent board members and non-executive members during the pandemic period. Legal requirements for Local Health Boards limited the length of time or tenure of members appointed so if a public appointments process did not take place to replace members the NHS in Wales would be in breach of statutory requirements. Recognising however that recruitment during the pandemic would be extremely challenging if not impossible to achieve, the Welsh Ministers made the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These Regulations temporarily (up to the 31 March 2021) disapplied the legal limits on the length of time board members could be in

office to minimise any disruption to the operation of the NHS in Wales and ensure continuity of service.

116. The second issue required changes to the model standing orders issued by the Welsh Ministers to provide flexibility around the requirement to hold an Annual General Meeting and to reflect the changes to the time limits for appointments. Updated model standing orders for use during the pandemic were issued in July 2020 and a copy is exhibited to this statement, reference **JPM3WGO02/04 - INQ000182591**. NHS bodies were required to make the necessary temporary variations to their Standing Orders and Reservation and Delegation of Powers as set out in the model standing orders in accordance with the Board and Committee timetable but no later than 30 July 2020.

117. The monitoring of the NHS in Wales performance by the Chief Executive NHS Wales, and by the Welsh Government changed during the pandemic period. The usual process of 3-year Integrated Medium-Term Plans (which set out how an NHS body would deliver services to meet the needs of their local population over a three-year period) 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 Local Health Boards for weekly plans in the early phase of the pandemic. These largely comprised of updates from the Local Health Boards on their capacity plans to respond to the Covid-19 pandemic and evolved over time to include plans for surge capacity. There were sometimes referred to as "Gold Plans". The plans submitted by Local Health Boards were helpful in providing important assurance to the Welsh Government about the NHS preparedness and response, and to help inform national approaches. This was in addition to the updates provided to the Welsh Government on NHS preparedness and response via regular conference calls with Dr Andrew Goodall and NHS Chief Executive Officers, the weekly meetings of the Covid-19 Planning and Response Group and the weekly meetings of the Acute Secondary Care Sub-Group.

118. I have exhibited below the first of such plans provided by Local Health Boards following a request from Dr Andrew Goodall on the national conference call with the NHS Chief Executive Officers on 11 March 2020:

a) Cardiff and Vale University Health Board dated 11 March 2020 at **JPM3WGO02/04a - INQ000479914** and **JPM3WGO02/04b - INQ000479916.**

b) Aneurin Bevan University Health Board dated 12 March 2020 at **JPM3WGO02/04c** – **INQ000479921**.

c) Hywel Dda University Health Board dated 12 March 2020 at **JPM3WGO02/04d – INQ000283251**[20]**.**

d) Powys Teaching Health Board dated 12 March 2020 at JPM3WGO02/04e – **INQ000479915**.

e) Cwm Taf Morgannwg University Health Board dated 12 March 2020 at **JPM3WGO02/04f - INQ000479920** .

f) Betsi Cadwaladr University Health Board dated 12 March 2020 at **JPM3WGO02/04g - INQ000479922**.

g) Swansea Bay University Health Board dated 12 March 2020 at **JPM3WGO02/04h - INQ000484912**.

119. The Inquiry has asked for copies of the plans submitted by Local Health Boards in the week commencing 12 April 2020. I have exhibited the plans that the Welsh Government has been able to locate from that week below:

a) Cwm Taf Morgannwg University Health Board dated 15 April 2020 at **JPM3WGO02/04i - INQ000484824.**

b) Swansea Bay University Health Board dated 15 April 2020 at **JPM3WGO02/04j - INQ000484833**.

c) Cardiff and Vale University Health Board dated 17 April 2020 at **JPM3WGO02/04k - INQ000484907**.

d) Aneurin Bevan University Health Board dated 16 April 2020 at **JPM3WGO02/04l - INQ000484919.**

[20] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000283251]

120. Once the position started to stabilise this changed to quarterly operational planning cycles which were introduced in or around 18 May 2020 to provide assurance across the system. The Inquiry has also asked me for copies of the last weekly plans that were sent by Local Health Boards before switching to quarterly plans. I have exhibited the last of the weekly plans submitted by Local Health Boards that the Welsh Government has been able to locate:

a) Swansea Bay University Health Board dated 15 May 2020 at **JPM3WGO02/04m – INQ000484845.**

b) Powys Teaching Health Board dated 19 May 2020 at **JPM3WGO02/04n – INQ000484921.**

c) Aneurin Bevan University Health Board dated 7 May 2020 at **JPM3WGO02/04o – INQ000484923.**

d) Cardiff and Vale University Health Board dated 29 May 2020 at **JPM3WGO02/04p - INQ000484854.**

121. The Local Health Boards may be able to provide a full suite of the weekly plans, should the Inquiry require them.

122. The Welsh Government did not prescribe or dictate the contents of the Local Health Board Plans but did issue Operational Planning Frameworks for each quarter to set out the requirements for the NHS in Wales. Local Health Boards were required to have regard to these Frameworks in the development of their plans. The Local Health Boards' individual governance arrangements should ensure that the Board itself had oversight of the plans to ensure that they fulfilled their operational and legal responsibilities. The Welsh Government Operation Planning Frameworks took into account the modelling and reasonable worst-case scenarios coming from the Technical Advisory Cell and Technical Advisory Group.

123. During the pandemic the Welsh Government did not usurp the operational responsibilities of the Local Health Boards and trusts. However, by issuing consistent and clear planning assumptions and templates for additional bed capacity requirements the Welsh Government tried to support those organisations and by

providing guidance which enabled the NHS in Wales to plan in the short term with a particular focus on NHS capacity. The quarterly plans were aligned with the Ministerial priorities and focused on the four harms:

a) Harm from Covid-19 itself.

b) Harm from an overwhelmed NHS and Social Care system.

c) Harm from reduction in non-Covid-19 activity.

d) Harm from wider societal actions/lockdowns.

e) I note for completeness that a fifth harm was added by the Technical Advisory Group in July 2021: harm arising from the way Covid-19 exacerbated existing, or introduced new, inequalities in our society.

124. For the relevant period the following frameworks were issued:

a) NHS Wales Operating Framework - quarter 1, exhibit **JPM3WGO02/05 - INQ000182468** refers. This Framework was to be read in conjunction with the following guidance in place at the time:

   i. The Welsh Government Framework for Recovery, exhibited in **JPM3WGO02/06 - INQ000349353**;

   ii. Covid-19 Infection Prevention and Control Guidance to NHS Wales, as exhibited in **JPM3WGO02/07 - INQ000088334**[21]**;**

   iii. Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential, as exhibited in **JPM3WGO02/08 - INQ000182443;**

   iv. The Hospital Discharge Service Requirements, as exhibited in **JPM3WGO02/09 - INQ000227334.**

b) NHS Wales Operating Framework - quarter 2, exhibit **JPM3WGO02/10 - INQ000336745**[22] refers. This Framework was to be read in conjunction with the following:

   i. The World Health Organization's Strength Adjusting Measures for Covid-19, as exhibited in **JPM3WGO02/11 - INQ000353016**;

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[21] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000352979]

[22] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000182460]

ii. The NHS Covid-19 Secondary Care Pathway, as exhibited in **JPM3WGO02/12 - INQ000353351**;

iii. The Faculty of Intensive Care Bridging guidance for Critical Care during restoration of NHS services, as exhibited in **JPM3WGO02/13 - INQ000353463**;

iv. The Wales Cancer Network update on Cancer Services, as exhibited in **JPM3WGO02/14 - INQ000353461**[23];

v. The Welsh Government's Rehabilitation: A Framework for Continuity and Recovery, as exhibited in **JPM3WGO02/15 - INQ000282092**;

vi. Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential updated on 12 June 2020 exhibited at **JPM3WGO02/16 - INQ000182461**;

vii. The Royal College of Emergence Medicine guidance on infection prevention and control approaches in emergency departments, as exhibited in **JPM3WGO02/17 - INQ000353469**;

c) NHS Wales Operating Framework – quarter 3 and 4, exhibit **JPM3WGO02/18 - INQ000182474** refers. This Framework was to be read in conjunction with the Health and Care Standards Framework (2015) to guide decision making, as exhibited in **JPM3WGO02/19 - INQ000353460.** It also included the following Annex documents set out below:

i. Annexes A and B, which covered the detail of the aspects that must be covered in plans, as exhibited in **JPM3WGO02/20 - INQ000353133**;

ii. Annex C, Maintaining Essential Services required during Non-Covid 19 Pandemic as exhibited in J**PM3WGO02/21 - INQ000353134**;

iii. Annex D, a planning minimum dataset, as exhibited in **JPM3WGO02/22 - INQ000353135**.

d) The Welsh Government Winter Protection Plan 2020-21, exhibit **JPM3WGO02/23 - INQ000300011** refers. This was to be read in conjunction with the Test Trace Protect strategy for Wales, as exhibited in **JPM3WGO02/24 - INQ000147253**[24]**.**

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[23] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227184]

[24] 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 [INQ000182447]

125. In December 2020 the Planning Framework 2021-22 was issued requiring organisations to develop an annual plan for 2021-22, as exhibited in **JPM3WGO02/25 - INQ000353194.** 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 Integrated Medium Term Plan's planning framework was brought back for the 2022-2025 period and the statutory process recommenced.

126. The quarterly plans submitted by the NHS in Wales were a significant change to the way in which the NHS in Wales planned its services and included new ways of working, maintenance of essential services, new infection prevention and control measures, testing, workforce planning, and the rapid construction of field hospitals, which I will touch upon later in this statement.

Classification and declassification of Covid-19 as a High Consequence Infectious Disease

127. On 10 January 2020, an extraordinary meeting of the four nations High Consequence Infectious Disease definition and list group was held to consider whether Covid-19 should be classified as a High Consequence Infectious Disease in the UK. The group consisted of representatives from the four nations' public health agencies. The outcome of the meeting is exhibited in **JPM3WGO02/26 - INQ000180593.** Whilst the group was of the view that there was uncertainty for two of the six criteria (high case fatality rate and ability to spread in the community and within healthcare settings), the group agreed that a precautionary approach was warranted and made an interim recommendation that the disease caused by the Wuhan novel coronavirus be classed as an airborne High Consequence Infectious Disease with immediate effect. In an email of the same date, Public Health Wales subsequently notified the Welsh Government of the classification of the Wuhan novel coronavirus as an airborne High Consequence Infectious Disease.

128. On matters regarding High Consequence Infectious Disease, Public Health England serves as the UK's co-ordinating lead under international health regulations and provides expert specialist advice and diagnostic facilities to the NHS in Wales that cannot be provided in Wales. Accordingly, the Welsh Government and Public Health Wales work very closely with Public Health England. There were not any High-Level Isolation Unit beds in Wales, and the only two High Consequence Infectious Disease treatment centres with High-Level Isolation Units were the Royal Free Hospital in

London and the Newcastle Royal Victoria Infirmary. An agreement was put in place with NHS England to ensure Welsh patients' access to High Consequence Infectious Disease treatment centres. As set out later in this statement a Unit was ultimately funded at University Hospital Wales and was available from May 2020.

129. Public Health Link guidance issued by the Chief Medical Officer for Wales on 24 January 2020, which I exhibit at **JPM3WGO02/27 - INQ000224481**[25], provided information and advice regarding Covid-19 and confirmed that, if detected, the patient would be transferred to an Airborne High Consequence Infectious Disease centre in England and Public Health Wales would undertake contact tracing and advise on ongoing management. This was the four nations procedure agreed by Public Health Wales and the office of the Chief Medical Officer for Wales with Public Health England and the Department of Health and Social Care.

130. The first confirmed positive case in Wales, admitted on 27 February 2020, was duly transferred to a High Consequence Infectious Disease bed at the Royal Free Hospital, as announced by the Chief Medical Officer for Wales on 28 February 2020.

131. On 19 March 2020, Covid-19 was declassified as an airborne High Consequence Infectious Disease in the UK. That decision was taken by the four nations High Consequence Infectious Disease definition and list group because it no longer met the High Consequence Infectious Disease criteria. The written announcement, exhibited at **JMPM3WGO02/28 – INQ000269843**[26], confirming the declassification noted that:

    a) UK public health bodies reviewed the most up to date information about Covid-19 against the UK High Consequence Infectious Disease criteria and determined that several features had now changed. In particular, more information was available about mortality rates (low overall), and there was now greater clinical awareness and a specific and sensitive laboratory test, the availability of which continued to increase.

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

[26] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000469293]

b) The Advisory Committee on Dangerous Pathogens was also of the opinion that Covid-19 should no longer be classified as a High Consequence Infectious Disease.

c) The World Health Organization continued to consider Covid-19 as a Public Health Emergency of International Concern, therefore the need to have a national, coordinated response remained.

d) Cases of Covid-19 were no longer to be managed by High Consequence Infectious Disease treatment centres only. Healthcare workers managing possible and confirmed cases should follow the national infection prevention and control manuals from the four nations, which included instructions about different personal protective equipment ("PPE") ensembles that are appropriate for different clinical scenarios.

132. Declassification therefore meant that Covid-19 patients could be treated in hospital settings in Wales in accordance with the relevant infection prevention and control measures (which was at that time the infection prevention and control guidance issued by the UK Government) without having to be transferred to High Consequence Infectious Disease treatment centres. It is my understanding that all of the subsequent work on modelling and planning of hospital capacity was informed by the decision to declassify Covid-19 as a High Consequence Infectious Disease and the resulting requirement to treat Covid-19 patients requiring hospitalisation within the NHS estate in Wales.

Modelling of Reasonable Worst-Case Scenarios, hospital capacity and workforce capacity to inform NHS operational planning and delivery

133. The reasonable worst-case scenario is a hypothetical scenario that is used to plan for potential emergencies. It is not a prediction or forecast.

134. At the outset of the Covid-19 pandemic, Wales did not have its own policy modelling capability, with five percent of UK numerical estimates being used to create a rough approximation of impacts using pan-flu reasonable worst-case scenarios. The impacts of epidemic in Wales were estimated on a population level basis using a Scientific Advisory Group for Emergencies ("SAGE") reasonable worst-case scenarios model which was based on work of Ferguson et al (Imperial College)

supplied to NHS England, Scientific Pandemic Influenza Group on Modelling, Operational sub-group ("SPI-M-O"), and SAGE. Using five percent of the UK population for Wales was standard practice prior to the pandemic. This figure was age adjusted in subsequent iterations of the modelling. Age adjustment slightly increased the projected health impacts for Wales. This approach was utilised early in 2020 to inform planning assumptions. When TAC was established the modelling and advice provided became more sophisticated.

135. As with SAGE and the work of SPI-M-O, policy modelling in the Welsh Government quickly became an important asset to help support policy formation and decisions, also in helping understand the pandemic impacts and providing scenarios for planning.

136. The initial models agreed by the All Wales National Modelling Forum were from NHS England and were based on Imperial College London model scenarios that were published in March 2020. These were then apportioned for Wales, with the peaks moved backwards and forwards in time based on trends, and with key model parameters updated as more data became available, for instance on the proportion of hospital cases requiring critical care.

137. A number of the UK modelling groups (Imperial College London, London School of Hygiene and Tropical Medicine, and University of Warwick) included Wales in their outputs on some occasions, enabling the Welsh Government's Technical Advisory Cell ("TAC") to compare and contrast the results for Wales across multiple models, considering the different starting assumptions and variables used. Where Wales-specific outputs were not available, TAC would take a proportion of UK or England based outputs, typically based on a proportion of the populations – adjusted for age where possible. From around May 2020, TAC commissioned specific policy modelling from Swansea University, led by Professor Mike Gravenor, who was also a SPI-M-O member. Initially this work was on an unpaid basis, however payment for this work arranged from 5 August 2020, around 2-3 months after Swansea University started working with the Welsh Government).

138. Public Health Wales supplied data to SPI-M-O modelling teams from 2 May 2020 and TAC gave advice on interpretation so that Wales could be included in SPI-M-O model outputs.

139. On 22 May 2020, SAGE agreed a new reasonable worst-case scenario, following the impact of lockdown. Unlike the previous model, the new scenario included disaggregated results for the four nations. It was modelled by four different academic groups for SPI-M-O, with the Warwick University model selected as lying in the middle of the estimates. TAC also modelled the impact of the Rt (the reproduction number) on admissions, bed occupancy and deaths in Wales, as exhibited in **JPM2WGO02/29 - INQ000469002**. The Warwick model and TAC model were similar in terms of the timings of peaks but varied in terms of the extent of the peaks. It was recommended that areas plan for the Reasonable Worst Case based on the Warwick model but continue to monitor the Rt and update projections of NHS activity based on these trends. Most importantly it recommended that there should be continued progress towards modelling policies for Wales.

140. In May 2020, a policy modelling group was established to discuss various models and data and to create bespoke modelling for Wales. TAC was responsible for providing scientific advice to the government on the pandemic response, and this included publication of modelling data. The modelling subgroup was part of TAC, and it produced a consensus statement on modelling, exhibited in **JPM3WGO02/30 - INQ000468977**. This stated that Wales-specific modelling had been conducted by Public Health Wales and the Welsh Government with input from the NHS and others. This modelling had taken into account factors like age structure, deprivation, and current rates of infection with associated hospital activity and deaths. The modelling did not specifically factor in urban and rural areas, but this had been considered and the modelling would factor this indirectly if it affected infection rates. The group was also inputting into modelling produced for SPI-M-O and short-term forecasting, which was carried out by academic groups for Wales, and was constantly refining the modelling with input from across the system as well as from academic groups. The group was also establishing model task and finish groups to provide better real time estimates of cases and demand.

141. Also in June 2020, funding was approved for policy modelling from Swansea University to develop a deterministic model for Wales. By August 2020, two Wales-specific models were available for use:

a) A deterministic model developed by Armakuni, working closely with Oxford University Big Data Institute, NHS England and Faculty AI; and

b) A stochastic model developed by Swansea University academics based on the London School of Hygiene and Tropical Medicine model - but seeded to Wales, that is, estimating the initial number of unique cases that came into Wales from triangulating genomics and confirmed case data.

142. As of September 2020, the Technical Advisory Group ("TAG") recommended that the Swansea University model be the official reasonable worst case for Wales. This was circulated to Local Health Boards via an email of 10 September 2020, noting that it did not change the NHS planning assumptions. The reasonable worst-case scenario was re-calibrated in September 2020 to account for the firebreak, and in preparing for the winter of 2020/2021 when specific models were developed with Swansea University and Armakuni.

143. In December 2020, estimates of quality adjusted life years and healthcare costs were included in the model results that were produced by Swansea University. This enabled the economic benefits of different control scenarios to be compared with potential economic costs, for instance from lost gross value added. These inputs were used to model the cost effectiveness of mass testing for Covid-19 that was piloted in Merthyr Tydfil.

144. The reasonable worst-case scenario for Wales during the pandemic included projections of the number of Covid-19 cases, hospitalisations, and deaths based on various factors such as population density, age demographics, and healthcare capacity. The scenario also considered the potential impact of new variants of the virus and the effectiveness of vaccines.

145. The modelling team in Wales worked closely with other modelling teams across the UK, including SAGE and SPI-M-O, to share data and ensure consistency in their projections. There were regular meetings of TAG where modelling was discussed and reviewed. The modelling team also worked with the Care Inspectorate Wales, Local Health Boards, Public Health Wales, Local Authorities, Welsh Ambulance Services NHS Trust, Social Care Groups (such as Social Care Wales) and academic partners.

146. Over the course of the pandemic several regular policy model outputs were produced with new data incorporated as it became available, including updates to the Swansea

model and reasonable worst-case scenarios and more bespoke pieces of work commissioned by Welsh Ministers and policy leads. The process of the development of each policy model was iterative. For example, the initial reasonable worst-case scenario models for Wales were developed by Armakuni and Swansea University modelling teams in parallel to the UK Government Cabinet Office's modelling to SAGE and the SPI-M-O subgroup for a reasonable worst case for the UK.

147. Whilst the model in Wales evolved throughout the pandemic it can generally be described as 'stochastic and LA structured' – meaning that the model took into account random events and chance occurrences, which could affect the spread of the disease. "LA structured" refers to the fact that the model considered the location and age of individuals within a population. The model then simulates the spread of the disease by tracking the movement of individuals between these groups and the transmission of the disease between individuals. The model also took into account factors such as the effectiveness of interventions like vaccination or social distancing measures. In particular, the Wales reasonable worst-case model considered non-pharmaceutical interventions and behaviour changes, herd and waning immunity and vaccine delivery.

148. The stochastic and LA structured model was useful for predicting the spread of infectious diseases in real-world populations, as it could account for the complex interactions between individuals and the environment. However, it is important to note that the accuracy of the model depends on the quality of the data used to create it, and the assumptions made in the model.

149. The reasonable worst-case scenario used by the Welsh Government and the NHS in Wales to produce demand and capacity models took into account local data, such as rural populations, as well as agreed parameters, including the reproduction number, doubling time, infection fatality rate, proportion of infected people hospitalised, fatality rate of hospitalised people, proportion of hospitalised patients requiring ventilation, fatality rate for people requiring invasive ventilation, proportion of cases asymptomatic, average length of stay in ICU. The reasonable worst-case scenario also made specific assumptions, for example school closures leading to an increase in contacts within the home by 100% and social distancing reducing workplace contacts by 25% and other contacts outside the home by 66%.

150. Four potential reasonable worst-case scenarios were assessed by the Policy Modelling TAG subgroup comparing them with each other and evaluating against a set of criteria to determine which might be the most suitable for Welsh Government and the NHS in Wales planning purposes. These reasonable worst-case scenarios were revisited regularly over the course of the pandemic by the subgroup to take account of, for example, new variants, the October 2020 firebreak, waning immunity, and the vaccine programme, with their recommendations for adaptations peer reviewed by TAG. With the generation of new reasonable worst-case scenarios came an assessment of past models with 'actuals' and assumptions (e.g. vaccination rates, emergence of variants etc). With repeated waves of Covid-19 and vaccination the policy modelling became more complicated. TAC and TAG published numerous papers analysing and validating past and new policy models for Covid-19, also extending analysis into other winter illnesses such as Flu and Respiratory Syncytial Virus to better understand and prepare for potential compound NHS winter pressures.

151. Over time the approach to policy modelling better reflected the trade-off between the costs and benefits of Covid-19 control measures to support the integrated impact assessments of Covid-19 protective measures to support decision making.

152. Alongside other tools and analysis, policy modelling played an important role throughout the pandemic. Despite its inherent uncertainties, policy modelling helped with 'what if' questions for pandemic preparedness and as such should be seen as one of several important tools in the scientific armament for risk assessment and risk management for system challenges like pandemics. As with SAGE and the work of SPI-M-O, policy modelling in the Welsh Government quickly became an important asset to help support policy formation and decisions, and in helping understand the pandemic impacts and providing scenarios for planning. Modelling and reasonable worst-case scenarios were routinely shared and discussed with the Health and Social Services Group Covid-19 Planning & Response Group, as well as NHS Chief Executives. These informed the development of national and local capacity planning assumptions and operational decisions, alongside consideration of operational assessments from and across the NHS.

Accuracy of the modelling projections

153. In the second TAG meeting on 4 March 2020, Public Health Wales and the Communicable Disease Surveillance Centre, led by Name Redacted, produced

demand projections for the NHS in Wales by simple application of the Imperial model to population of Wales using spreadsheet calculations. The projections considered different population areas in Wales at Local Health Board level and considered a range of reasonable worst-case scales (25%, 50%, 75% and 100%). The modelled outputs estimated that new cases would peak 11 weeks from start of epidemic and demand for services could peak around weeks 12-14. There were considerable variations by health boards 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 gives lower demand – but even with a 25% scaling, demand would exceed supply (>12000 prevalent cases requiring hospitalisation and 6,338 Covid related deaths). By the end of wave one after significant imposition of population protections there were over 2,500 deaths in Wales where Covid-19 was mentioned on the death certificate. Up to May 2023 there had been 11,871 deaths where Covid-19 was involved. The Imperial model did overestimate the number of people who would require intensive care support than was realised, this in part was because the ICU capacity was full and other means of treatment or triaging for patient requiring such care would have been sought (e.g. non-invasive management of hypoxia). Given that slight changes to some of the assumptions (e.g. basic reproduction ratio or infection fatality ratio) can have a significant impact on the modelled outputs in any epidemic model the first reasonable worst-case scenario with interquartile breakdowns proved a sensible projection of the potential impacts of the pandemic in Wales.

154. The following are further comparisons between the modelling predictions and actual figures:

a) Modelling predictions in Wales at the start of the pandemic indicated that there would be 2,400 deaths in Wales from 30 March to 30 September 2020. According to the Office for National Statistics (ONS), there were 2,529 deaths involving Covid-19 registered in Wales between 30 March and 30 September 2020.

b) The Swansea reasonable worst-case scenario predicted a peak of Covid-19 cases and deaths in December 2020, however the second peak in Wales occurred in January 2021.

c) The reasonable worst-case scenario produced for the 2020-21 winter period predicted total numbers of Covid-19 admissions and deaths of 18,200 and 6300 respectively would occur between 1 July 2020 and 31 March 2021, while the actual data indicated numbers of 15,200 and 4000 respectively. This reasonable worst- case scenario provided an early warning for the potential of a winter second wave.

d) In the proposed reasonable worst-case scenario, between 22 February 2021 and 30 June 2021 the total numbers of cases and deaths were estimated to be 194,161 and 3946. The proposed most likely scenario (MLS) estimated cases and deaths at 57,866 and 806, respectively. The actual figures for the period were 15,743 cases and 306 deaths.

155. The models were scenarios and were not intended to predict the future, but generally speaking, what was observed in terms of NHS pressures was within the scenarios chosen. The models would generally predict a wave of a given magnitude – sometimes the wave was bigger or smaller, and sometimes the timing was different.

156. In May 2022, TAG produced a Modelling Retrospective document, exhibited in **JPM3WGO02/31 – INQ000469151**, which compared historic modelling in Wales with actual Covid-19 data. The report highlighted that reasonable worst-case models were not predictions and that there were many uncertainties such as level of adherence to, and choice of, population protections, vaccine effectiveness, waning immunity and evolution of variants. As a result, models captured plausible key assumptions and explored scenarios based on those assumptions. In general, the outcomes in the different reasonable worst-case scenarios were not met, in part due to the implementation of Non-Pharmaceutical Interventions. The numbers did not reach the levels predicted in most model scenarios with cases, deaths and admissions closer to the lower end of the varying levels projected. However, the large peak expected in the models did actualise soon after – with the wave accelerating in August and peaking in September to October 2021. Generally, the actual outcome was 'better' than the optimistic scenarios rather than worse than the pessimistic scenarios. Where actual outcomes were worse this was generally because of a new variant that was not anticipated.

Sitreps

157. As the Welsh Government is not responsible for operational decision making within the NHS in Wales, and as a result of the legal independence of each Local Health Board and Trust, the Welsh Government does not as a matter of course monitor or receive detailed operational data. During the Covid-19 pandemic the Welsh Government was able to access or request, should it be necessary, the data required to inform planning and decision making. The Situation Reports ("sitreps") developed for the pandemic response presented data on an all-Wales level as well as allowing a breakdown by each Local Health Board or individual hospital on any given day. The daily sitrep was provided by each individual Local Health Board and submitted to NHS Wales Informatic Services (later Digital Health and Care Wales) for them to collate into a single report. This report was then forwarded to the Welsh Government NHS Performance team who provided daily summary reports to senior officials and others as outlined above. Sitreps were shared on a daily basis with senior officials within the Welsh Government, as well as with those coordinating the response which included military personnel, NHS staff in Local Health Boards and Trusts and colleagues in England. The reports were shared seven days a week at the start of the pandemic. Once the initial wave was over and the numbers started to reduce, the circulation of the report went to five days a week, with an update for the weekend being shared on the Monday. The Director General of Health and Social Services Group then summarised the information to provide updates to Ministers.

158. The data that was circulated was the information collected in the sitrep at that particular moment in time. Initially this just included bed numbers and the number of people in those beds and the empty beds in hospitals, split by those with and without Covid-19, but this was then extended to collect other data relating to equipment, oxygen supplies, admissions, deaths, mortuary capacity. As of 30 April 2020, field hospital capacity and private hospital capacity also started being reported. Data was also later made available for occupancy in community hospital beds and on the number of operations postponed. Figures had a comparison to the previous day's figures so recipients of the data could easily track trends and statistical analysis where required, and sitreps could be filtered to show data per hospital or Local Health Board if required. The sitreps were therefore an up to date and ever-changing source of data in line with policy and practical changes being made. Whenever there was a change in the sitrep data collection, a new version of the sitrep was circulated.

159. Sitreps were a valuable tool in communicating detailed data and relevant information between the NHS in Wales and the Welsh Government both prior to and during the pandemic. The sitreps provided a detailed and up-to-date picture of the situation in Wales, which allowed the Welsh Government to make informed decisions about how to respond to the pandemic. They provided a snapshot of the current levels of Covid-19 and whether the numbers were increasing or decreasing and where additional support may be required. They were used to monitor the spread of the virus and to identify areas where additional measures were needed to control transmission. The reports were also used to track the impact of interventions, such as lockdowns and social distancing measures, and to assess whether they were having the desired effect.

Welsh Government's role in the gathering, analysis and dissemination of information within the healthcare system

160. I have been asked to describe the Welsh Government's role in the gathering, analysis and dissemination of information within the healthcare system during the relevant period.

Encouraging liaison with international clinical colleagues

161. The Welsh Government encouraged liaison with international clinical colleagues during the Covid-19 pandemic. The government recognised that the pandemic was a global issue and that there was a need to share information and best practices with colleagues around the world. To facilitate this, the Welsh Government established partnerships and collaborations with international healthcare organisations and experts. For example, the government worked closely with the World Health Organization and other international organisations to share information and coordinate efforts to manage the pandemic. The Welsh Government participated in World Health Organisation briefings and meetings and collaborated with the Organisation on research projects and clinical trials. There were similar collaborations with the European Centre for Disease Prevention and Control, the International Society for Infectious Diseases and the International Severe Acute Respiratory and Emerging Infection Consortium.

162. An international TAG subgroup group chaired by the Welsh Government's Head of Science branch known as the IntTel TAG group looked at information, evidence and

experiences of other countries in relation to the pandemic and how other countries managed their pandemics. IntTel TAG produced situation reports weekly for a considerable period and these charted the progress of the pandemic across the world. IntTel TAG also produced bespoke reports which were distributed to TAG and Ministers as appropriate – these tended to be specific issues which were particularly relevant at the time. The Welsh Government's international offices provided 'in country' intelligence of what was happening, and the actions being taken by governments to control the virus. However, this work did not include engagement with international clinical colleagues or local health services and so was most useful for 'big picture' assessments rather than detailed clinical practices. IntTel TAG included representatives from Public Health Wales so information and evidence that was gleaned by the groups was shared with Public Health Wales for its use as a secondary route for decision making by the health services.

Sharing understanding and innovation from clinical experience across NHS Health Boards and promoting or arranging online learning opportunities for clinicians.

163. There were regular briefings held by the Welsh Government with clinicians and Local Health Boards, and medical royal colleges and professional unions during the Covid-19 pandemic. These were chaired by the Chief Medical officer for Wales, Sir Frank Atherton, and typically included updates on the latest developments related to the pandemic, as well as guidance on how to manage patients with Covid-19. The briefings also provided an opportunity for clinicians and Local Health Boards to ask questions and provide feedback to the government. The Chief Medical Officer for Wales was supported by other senior officials from the Welsh Government, including the Chief Nursing Officer, the Director General of Health and Social Services, and the Deputy Chief Medical Officer. These officials provided updates on issues such as staffing levels, equipment and supplies, and the availability of hospital beds. The briefings were also attended by representatives from Local Health Boards, primary care providers, and other healthcare organisations. These representatives were given the opportunity to ask questions and provide feedback on the government's response to the pandemic. The briefings were an important way for the Welsh Government to communicate with healthcare providers during the Covid-19 pandemic, and to ensure that healthcare providers had the information and resources they needed to manage the pandemic effectively.

164. The Covid-19 Primary Care Group was established to provide guidance on the management of patients with Covid-19 in primary care settings. The group included representatives from primary care providers, as well as experts in areas such as infectious diseases and public health.

165. The Covid-19 Planning & Response Subgroup on Acute Secondary Care was responsible for developing plans and strategies to ensure that the acute secondary care system in Wales was prepared to manage the pandemic effectively. The subgroup was made up of representatives from Local Health Boards, Welsh Ambulance Services NHS Trust, and other healthcare organisations. The group was chaired jointly by the Welsh Government's Deputy Chief Medical Officer, Professor Chris Jones and NR Chief Operating Officer at Cardiff and Vale University Health Board at the time. The subgroup's responsibilities included:

a) Developing plans for the management of patients with Covid-19 in acute secondary care settings, such as hospitals.
b) Ensuring that there was sufficient capacity in the acute secondary care system to manage the pandemic, including the availability of hospital beds, staffing levels, and equipment and supplies.
c) Developing protocols for the safe transfer of patients with Covid-19 between healthcare settings, such as from hospitals to care homes.
d) Coordinating efforts to ensure that healthcare providers had access to appropriate PPE to protect themselves and their patients from Covid-19.
e) Developing plans for the management of non-Covid-19 patients in acute secondary care settings during the pandemic, to ensure that they continued to receive appropriate care.

166. These groups helped to ensure that healthcare providers had access to the latest information and best practices for managing the pandemic effectively.

167. The first meeting of the Covid-19 Subgroup on Acute Secondary Care recognised that clinical advice on the management of Covid-19 would be rapidly changing with the evolving evidence base and would need to be spread rapidly to all clinicians in Wales. Therefore, a mechanism was required to share the latest information on the assessment and management of Covid-19 to avoid unwarranted variation in clinical practice across Wales. Prior to the pandemic, there was a National Clinical Lead for

Wales for respiratory medicine from the Cardiff and Vale University Health Board, who led via a national Respiratory Health Implementation Group. This group had undertaken considerable work pre-pandemic in collaboration with the Institute of Clinical Science and Technology, an independent, clinically led company based in Cardiff.

168. During the pandemic, pathways and educational resources were developed by the Institute of Clinical Science and Technology, which included a large number of educational videos presented by Welsh clinicians pushed directly to individual clinicians by email notification, providing a link to the national pathways and training material to create and spread high quality evidence based clinical guidance, rather than via more traditional methods of cascade from national to Local Health Board executive level and then down through management chains to individual clinicians. As the pandemic evolved and the understanding of the disease's management improved, these guidelines, pathways and educational materials were updated quickly and disseminated immediately and directly to clinicians, often within 24-48 hours. The educational material covered the assessment, management and treatment of the condition in multiple settings, such as emergency and acute medicine departments, ward-based care, and critical care. Given the number of non-specialists in respiratory and critical care medicine that were redeployed to Covid-19 care, this work was pivotal in helping to ensure that clinical teams could get up to speed with quality assured information and that all Local Health Boards in Wales had a common understanding of the management of Covid-19 in a hospital setting. The way this information was delivered also permitted data collection on engagement by the clinical community to support better adoption and was so successful that later in 2020, the clinical guidance and pathways for clinicians in the community was moved over onto the same digital platform as part of an extension to the contractual arrangement.

Identifying themes from sitreps or other routine reports

169. Welsh Government officials analysed sitrep data on a daily basis, looking at what the information from the previous day/week was saying when compared to the current day. The data also stated whether this was the highest ever, or the highest/ lowest since a specific date, depending on whether the numbers were increasing/ decreasing. As outlined above, the data was shared with senior officials in the Welsh Government, together with those coordinating the response outside of the Welsh

Government, such as the Gold command teams in Local Health Boards. A high-level analysis of the data, it included a narrative of, for example, where all Wales and Local Health Board numbers of confirmed cases in hospital had increased compared to previous periods along with graphs to show trends. Data was also shared in graph form from the sitrep which was used to brief Ministers on areas such as overall bed occupancy and numbers in hospital with Covid-19.

Facilitating interdisciplinary collaboration within the NHS

170. The COVID-19 Planning & Response Subgroup on Acute Secondary Care, chaired by Professor Chris Jones and NR referred to above, embodied interdisciplinary collaboration within the NHS as its membership included representatives from Local Health Boards, Welsh Ambulance Services NHS Trust, and other healthcare organisations.

171. In addition, the COVID-19 Moral and Ethical Advisory Group for Wales ("CMEAG-W") had professional and public membership and was an interdisciplinary and public sounding board for policy leads to utilise to test policy proposals especially in terms of protected characteristics and underserved groups of the community. This group met regularly and was greatly valued in assisting policy leads to address equity issues in planning and decision making.

Mechanisms in place during the relevant period for Welsh NHS bodies to input or share data relating to NHS activity and capacity to ensure that all decision makers had access to the same information

172. During the Covid-19 pandemic, NHS bodies in Wales worked together to share data relating to NHS activity and capacity to ensure that all decision makers had access to the same information. This was done to support the planning and delivery of healthcare services during the pandemic and to ensure that resources were allocated effectively.

173. One of the key mechanisms for sharing data was the NHS Wales Informatics Service, later to become Digital Health and Care Wales, which provided a range of digital health and care services to support healthcare providers in Wales. The National Wales Informatics Service developed a range of tools and systems to enable the sharing of data between NHS bodies, including electronic patient records, clinical systems, and digital imaging.

174. In addition, the Welsh Government established the Covid-19 Intelligence Cell to coordinate the collection and analysis of data relating to the pandemic. The Intelligence Cell's purpose was to act as a single, authoritative source of situational awareness for Covid-19, including all associated Variants of Concern, and the introduction of new tests and vaccinations across Wales, and to provide a comprehensive picture of the impact of the pandemic on health and social care services in Wales. It brought together data from a range of NHS, Public Health Wales, local authority and wider sources, including:

   a) The Communicable Disease Surveillance Centre in Public Health Wales.

   b) Data and intelligence from public health professionals about the local or regional context, including Directors of Public Protection and Directors of Public Health.

   c) Data and intelligence, including information from Incident Management Teams and Outbreak Control Teams, from the Covid Intelligence Group.

   d) Data from Test Trace Protect systems.

   e) Expertise from Virology in Public Health Wales as required.

   f) The Welsh Government's Technical Advisory Group, Technical Advisory Cell and Knowledge and Analytical Services.

   g) Cross UK data and intelligence, including assessment of risk in context of international travel to the UK, from the UK Health Security Agency (previously the Joint Biosecurity Centre).

175. The data collected by the Intelligence Cell was used to inform decision making at all levels of the healthcare system, from Local Health Boards to the Welsh Government. This ensured that decision makers had access to the same information and were able to make informed decisions based on the latest data and evidence.

176. Overall, the sharing of data between NHS bodies in Wales was a critical component of the Covid-19 response, enabling healthcare providers and decision makers to work

together to deliver high-quality care and manage the impact of the pandemic on health and social care services in Wales.

177. Raw data was submitted to and collated and analysed by the National Wales Informative Service and then Digital Health and Care Wales before being presented to the Welsh Government in the form of sit-reps and interactive database Stats Wales and the COVID-19 dashboard. The dashboard provided real-time data on the spread of the virus, hospital admissions, and other key indicators. Stats Wales was used to track the spread of Covid-19 in Wales and to monitor the impact of the pandemic on health and social care services. This public database provided data on the number of Covid-19 cases, hospital admissions, and deaths, as well as information on the availability of hospital beds, ventilators, and other critical resources.

178. In addition, Digital Health and Care Wales worked to ensure that patients and the public had access to accurate and up-to-date information on Covid-19. They developed a range of digital resources, including a Covid-19 symptom checker and a virtual assistant, to help patients and the public understand the virus and access the care they needed.

Mechanisms in place during the relevant period for Welsh Government or Welsh NHS bodies to transmit emergency alerts or disseminate information, policies and guidance to the intended recipients (whether national bodies, regional bodies, individual Trusts or others)

179. From 24 January 2020, the Chief Medical Officer for Wales began issuing public health links, or “CMO alerts” as they were also often referred to.

180. This was an established method of cascading important timely information to the NHS in Wales and other key stakeholders. The distribution list for the Public Health Link was as follows:

   a. All General Practitioners, with a note to ensure the message was seen by all nurses and non-principals working in their practice and to retain a copy in their ‘locum information pack’.
   b. All Community Pharmacists
   c. Deputising services
   d. Local Health Board Chief Pharmacists

e. Local Health Board Prescribing Advisers
f. Independent/Private clinics and Hospitals and Hospices throughout Wales
g. Local Health Boards and NHS Trusts
    i. Chief Executives
    ii. Medical Directors
    iii. Nurse Directors
    iv. Directors of Public Health
    v. Hospital Principals and Chief Pharmacists
    vi. Immunisation Leads
    vii. Infectious Disease Departments
    viii. Acute medical units
    ix. Microbiologists
h. Public Health Wales
i. Chief Executives
j. Director of Public Health Services
k. Consultants in Communicable Disease Control
l. Microbiologists
m. Consultant Epidemiologists
n. Vaccine Preventable Disease Programme
o. NHS Direct Wales
p. British Medical Association
q. Royal College of GPs
r. Royal College of Nursing
s. Royal College of Midwives
t. Royal Pharmaceutical Society
u. Community Pharmacy Wales
v. Royal College of Paediatrics and Child Health Wales

181. The purpose of the alerts was to inform and reassure the NHS, address pressing concerns and highlight any guidance or key advice. While these are referred to as CMO alerts these would be from the office of the Chief Medical Officer for Wales so not always signed by the Chief Medical Officer himself. Alerts could also be issued in collaboration with others such as the Chief Medical Officers for England, Scotland and Northern Ireland, the Chief Nursing Officer for Wales or Chief Pharmaceutical Officer for Wales. A list of all the public health alerts issued by the office of the Chief Medical Officer for Wales for the relevant period is provided at exhibit **JPM3WGO02/32 – INQ000252575.**

182. The Welsh Government also used Welsh Health Circulars and letters from the Chief Medical Officer and Deputy Chief Medical Officer to Local Health Boards on the treatment of Covid-19.

Mechanisms in place during the relevant period for those working on the frontline of healthcare to share information across healthcare systems (including between bodies in different countries of the UK) relating to problems encountered, solutions to problems, or other innovation in order to improve the response to the pandemic

183. Dr Goodall has described the formal and informal mechanisms in place at Government level for Wales to collaborate and coordinate across the four nations in the corporate statement of the Health and Social Services Group (reference: M3-WGO-01). Individual healthcare bodies and organisations providing frontline services throughout the NHS in Wales will have had their own systems and arrangements in place to collaborate and share information.

184. The Welsh Government facilitated the sharing of information across healthcare systems by providing digital platforms and tools to facilitate communication and collaboration between healthcare providers. For example, many healthcare providers used video conferencing and other digital tools to hold virtual meetings and share information in real-time. In addition, healthcare providers in Wales were able to access information and guidance from other healthcare systems in the UK through a range of channels, including online resources, webinars, and other training opportunities. This allowed healthcare providers to learn from the experiences of others and to adopt best practices and innovative solutions to improve the response to the pandemic.

185. The Welsh Government does not have specific details of the mechanisms used by frontline health care workers to share information across healthcare systems in Wales and in the UK.

Mechanisms in place during the relevant period to monitor the efficiency of communication within the healthcare system

186. During the Covid-19 pandemic, several formal mechanisms were in place in Wales to monitor the efficiency of communication within the healthcare system. These mechanisms were put in place to ensure that healthcare providers had access to the

information they needed to deliver care to patients and to ensure that communication was efficient, effective, and timely.

187. The online Covid-19 clinical guidance and education pathways described earlier in this statement were delivered on a digital platform that tracked the number of interactions by individual Local Health Board, hospital and profession. The data was used to prompt better uptake of the national tool.

188. Healthcare providers themselves also had mechanisms in place to monitor communication within their organisations. For example, many hospitals and Health Boards established Incident Management Teams to coordinate the response to the pandemic and to ensure that communication was efficient and effective.

189. In addition to those more formal mechanisms, the size, structure and closeness of pre-existing working relationships, with a focus on partnership and collaboration, were significant advantages in ensuring there was effective and consistent communication between NHS bodies and between NHS bodies and the Welsh Government.

190. The NHS Wales Leadership Board meetings were held monthly and were chaired by the Director General of the Health and Social Services Group. These meetings dealt with a wide range of topics including NHS finance and performance, service and workforce planning and service quality developments. During the pandemic, whilst some business as usual topics continued, it was also a forum to share information on the pandemic. In the early part of the pandemic, Dr Goodall also set up weekly Chief Executive Calls, which included all NHS Chief Executive Officers and some directors from Welsh Government. The frequency of these meetings started at three per week, but this varied at times and then tapered down over the course of the pandemic. There was no agenda for these meetings during the pandemic as they were reactive, and the issues covered varied in response to the rapidly changing situation.

191. In addition, Medical Directors and Nurse Directors were in regular contact with Dr Goodall or myself, the Chief Medical Officer and Chief Nursing Officer throughout the relevant period. In my experience, both within Aneurin Bevan University Health Board and Welsh Government, I found the system of communication and collaboration to be excellent both within the NHS, with Welsh Government and with broader public service partners.

Capacity

192. The Inquiry has asked me for information about the capacity in the NHS. In order to address these questions, I have received support from Samia Edmonds (Planning Director).

How capacity is defined and measured

193. Before the pandemic, data on bed availability and occupancy was collected monthly from individual Local Health Boards in Wales by NHS Wales Informatics Service and was subject to validation checks centrally prior to publication. As the services in the NHS in Wales are not provided or run by the Welsh Government but by Local Health Boards, it was the responsibility of those organisations to ensure that the figures were compiled correctly in accordance with central definitions and guidelines.

194. The annual statistics were published on the Welsh Government website. The data on NHS bed availability and occupancy was primarily used by those involved in planning and decision making at the national and local level but not specifically linked to pandemic or surge planning. The data was also used in a variety of other ways. Some examples of these include advice to Ministers, to assess, manage and monitor NHS activity in Wales; to inform service improvement projects for areas of focus and opportunities for quality improvement and by Local Health Boards, to benchmark themselves against other Local Health Boards.

Overview of the different categories of beds within the NHS

195. The Inquiry has asked me to provide an overview of the different categories of beds within the NHS. In Wales, the categorisation of beds and the range of staff, medical equipment oxygen and other resources available to such beds, and the extent to which they can be re-allocated for other usage, varies by hospital and/or Local Health Board. It is not information held at a national level by the Welsh Government. This local categorisation will likely include general and surgical beds and a wide range of specialty specific beds including paediatrics and neo-natal, learning disability, maternity, mental health, major trauma, renal, cardiac, respiratory, orthopaedic, neuroscience, gastrointestinal, care of the elderly and palliative care, etc.

196. General and Acute Beds are beds for medical and surgical care. They cater to a wide range of patients with various health conditions.

197. Adult critical care beds are specifically for patients requiring intensive care or high-dependency care and are available for critical care patients except for pediatrics.

198. During the Covid-19 pandemic, the NHS in Wales categorised beds within the sitreps as either critical care beds (which were specifically for patients requiring level 3 intensive care or level 2 high dependency care regardless of whether they were occupied by invasively ventilated patients or not) and other non-critical care beds. The categories were then split as follows:

   a) Critical Care:
      i. Beds in a general critical care unit. These would have access to equipment required to support the level of care needed such as ventilators which can provide invasive ventilation, monitoring, syringe drivers and renal dialysis if required.
      ii. Temporary critical care beds outside of general critical care unit. These beds would have been within acute hospital sites but would have been surge beds not normally used to provide critical care. These would have had access to similar levels of equipment as the main critical care beds with the exception of access to renal dialysis.
      iii. Beds in a specialist ring-fenced critical care unit including burns, cardiac and paediatric.

   b) Other non-critical care:
      i. Total designated Covid-19 hospital beds. In general, these all had access to oxygen and in certain areas would have also had access to non-invasive ventilation such as CPAP.
      ii. Non designated Covid-19 hospital beds
      iii. Specialist ring-fenced hospital beds including burns, renal, cardiac etc. The equipment would vary depending on the type of bed e.g. renal beds would have access to renal dialysis.

199. Within the Covid-19 sitrep data, it was then the hospital type which defined the bed – whether it was in an acute/major hospital (i.e. those which have an emergency department), community hospital, specialist acute hospital, mental health hospital, field hospital or private hospital.

200. The sitrep data excluded paediatric beds. However, from November 2021, a separate paediatric sitrep was produced collecting data on the number of paediatric critical care beds, as well as other general acute paediatric beds and neo-natal beds. This was produced specifically for Covid-19 so covered other respiratory illnesses as well.

201. The procurement of and provision of specialised wards, medical equipment, oxygen, staffing or other resources required for each of the above type of beds, and the extent to which beds of one type can be re-allocated for other usage this information was managed at a local level. As a result, specific data is not routinely reported to the Welsh Government. However, the Welsh Government did, through its strategic role in NHS bodies' planning and response as described above, play an important part in supporting NHS bodies in this regard.

202. In addition, data was captured on the Covid-19 status of patients (see paragraphs 445 - 454 of the corporate statement of the Health and Social Services Group, reference M3-WGO-01):

    a) Suspected- monitoring all suspected and confirmed cases allowed an understanding of overall capacity impact and constraints as effective Infection Prevention and Control and pathways required the system to be capable of managing all of these patients as Covid-19 patients.

    b) Confirmed- monitoring confirmed cases facilitated surveillance of the virus at the population, geographic and organisational level.

    c) Recovering- monitoring recovering patients provided an understanding of the ongoing impact of Covid-19 patients after their initial infectious period but whilst capacity was still affected. Monitoring the length of stays and how patients could be moved on informed planning.

Overview of capacity of the NHS in Wales prior to the pandemic

203. To provide an overview of the capacity of the NHS in Wales immediately prior to the start of the pandemic (in January - March 2020) the figures below have been compiled from the monthly NHS bed data collected by NHS Wales Informatics Service (which has since become Digital Health and Care Wales) and the average daily occupancy levels.

204. The data set out in the table below shows the NHS beds data that was available to the Welsh Government but does not specifically separate out inpatient beds. The figures set out include all inpatient beds (including special care baby units and intensive therapy units for babies) but excludes:

a) Labour (first and second stage) as distinct from maternity beds.

b) Beds in reception wards, unless in permanent use in psychiatric hospitals.

c) Temporary beds (or stretchers) unless in permanent use in psychiatric hospitals.

d) Observation or recovery beds used for only a few hours, whether in out-patients departments or recovery units.

e) Beds used solely for regular day or night patients.

f) Cots for normal newly born infants in maternity departments.

g) Beds specifically allocated for healthy people.

h) Beds used for day cases.

The 'average daily occupied beds' as set out in the table below is the average daily number of beds occupied by patients under the care of a consultant in a particular speciality.

Table 4: Table showing the NHS beds data, as reported by StatsWales

	All NHS beds (including intensive care)				Intensive care beds				
	Average daily available beds	Available beds per 100,000 population	Average daily occupied beds	Percentage occupancy	Average daily available beds	Available beds per 100,000 population	Average daily occupied beds	Percentage occupancy	Population estimates
Jan-20	10,761	347	9,428	87.6	172	6	123	71.4	3,104,483
Feb-20	10,599	341	9,287	87.6	158	5	123	78.0	3,104,483
Mar-20	10,509	339	7,902	75.2	204	7	117	57.2	3,104,483

205. Whilst occupancy rates were provided, information on 'associated resources' was not available to the Welsh Government at the time and is not held by the Welsh Government now. The data provided in the table is based on a long-standing data collection which is not directly comparable with the Covid-19 sitrep-based data that

was collected from March 2020 onwards, which was the basis of analyses of capacity and occupancy during the pandemic. The sitrep provided a more comprehensive view of true capacity, particularly Covid-19-specific capacity.

206. Data on the number of ventilators available across the NHS in Wales, per 100,000 of the population in the pre-pandemic period is not held by the Welsh Government.

207. The Inquiry has asked for the number of vacancies in healthcare workers roles across the NHS in Wales, and as a percentage of the NHS healthcare workforce in Wales for the period immediately prior to the start of the pandemic. NHS vacancy statistics are not compiled or reported by the Welsh Government. The information was held at an organisational level by each team and, should the Welsh Government need or request it, readily available. NHS vacancy statistics were only collected from 31 Dec 2022 onwards. The data from this point onwards has been sourced from StatsWales which maintains a catalogue online of NHS Staff vacancies and has been set out in the table below. A "vacancy" is define as the difference between the number of funded full-time equivalent ("FTE") posts as recorded on the finance general ledger, and the number FTE staff in post as recorded on the Electronic Staff Record at a point in time. The vacancy rate is the number of vacancies divided by the number of funded FTE posts recorded on the general ledger.

Table 5: Table showing NHS Staff vacancies

NHS staff vacancies by organisation, staff group and date

	31/12/2022		31/03/2023		30/06/2023		30/09/2023	
	FTE vacancies	Vacancy rate (%)	FTE vacancies	Vacancy rate (%)	FTE vacancies	Vacancy rate (%)	FTE vacancies	Vacancy rate (%)
All staff groups	4,960	5.3	4,277	4.5	5,982	6.2	6,075	6.2
Medical and dental (excluding trainees)	426	8.9	475	9.7	537	10.7	506	10.1
Nursing, midwifery and health visiting (registered) (	2,402	8.9	2,290	8.4	2,667	9.7	2,581	9.3
Nursing, midwifery and health visiting (support)	813	6.2	510	3.9	856	6.3	772	5.7
Administration, estates and facilities (2)	833	2.9	475	1.6	1,149	3.8	1,479	4.9
Scientific, therapeutic and technical	362	2.2	412	2.5	650	3.8	601	3.5
Ambulance	122	3.6	115	3.4	122	3.6	137	4.1

208. The Inquiry has also asked for the number of physicians per 100,000 of the population in Wales for the period immediately prior to the start of the pandemic. The data for doctors employed by the NHS and doctors employed in general practice is collated separately because General Medical Practitioners are independent NHS contractors and so not included in the NHS data. Data for workforce is collected on a quarterly

basis on a cycle of March, June, September and December. This is collated based on the FTE contract which is 37.5 hours per week and the population based on the Office of National Statistics mid-year estimates for each year.

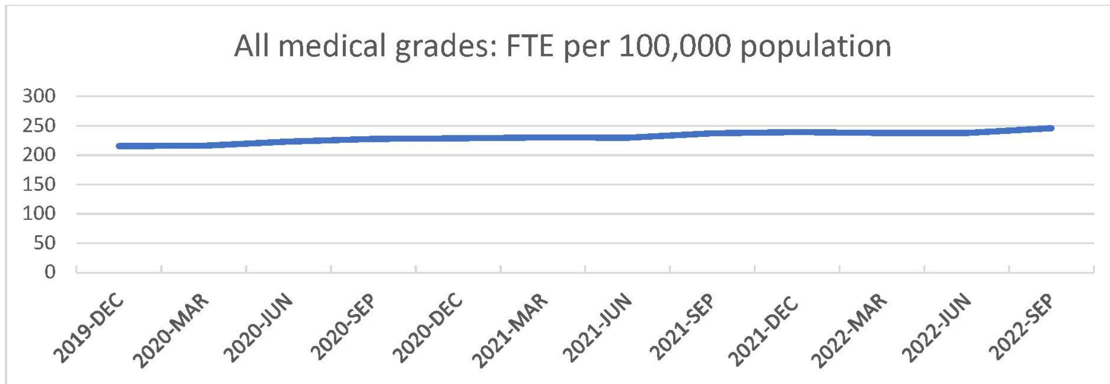
209. I have set out below a table showing the number FTE doctors employed by the NHS per 100,000 of the population for the period 2019 to the beginning of the pandemic in March 2020:

Table 6: Table showing number of FTE doctors employed by the NHS per 100,000 population from March 2019 to March 2020

Month/year	**Number of FTE doctors employed by the NHS per 100,000 population**
March 2019	208
June 2019	206
September 2019	214
December 2019	215
March 2020	216

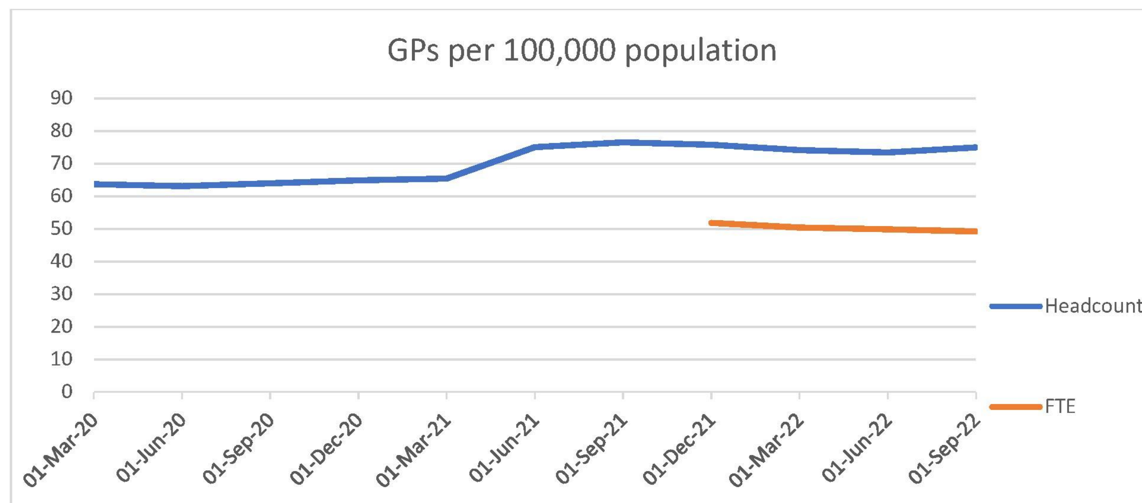
210. To assist the Inquiry, I have also provided a graph showing the number of FTE doctors employed by the NHS per 100,000 population for the period December 2019 to September 2022, which shows a gradual increase in the numbers employed.

Figure 4: Graph showing the number of FTE doctors employed by the NHS for the period December 2019 to September 2022



211. The equivalent data for FTE of fully qualified GPs per 100,000 was not consistently collected until December 2021 and therefore the Welsh Government does not hold such information for the pre-pandemic period. The Welsh Government does however hold headcount of fully qualified GPs per 100,000 population from March 2020 onwards. To assist the Inquiry, I have provided below a graph showing the headcount data of fully qualified GPs per 100,000 population for the period March 2020 to September 2022, and the FTE equivalent data per 100,000 population for the period December 2021 to September 2022. The increase between March 2021 and June 2021 in the headcount data is mainly due to the inclusion of GP locums which were not included prior to that date.

Figure 5: Graph showing the headcount of fully qualified General Practitioners for the period March 2020 to September 2022, and the number of FTE fully qualified General Practitioners for the period December 2021 to September 2022



212. NHS England also publish NHS staff statistics, but coherence work undertaken by the Welsh Government Statistics team has shown that the data is not directly comparable between countries as staff are counted differently.

Awareness of issues or concerns relating to capacity of the NHS in Wales prior to the pandemic

213. Prior to the Covid-19 pandemic, I am aware that there had been issues raised in relation to workforce and critical care capacity within the NHS in Wales. In August 2017, the Critical Illness Implementation Group, which oversaw the Welsh Government's delivery plan for the critically ill concluded that critical care services in Wales were improving but that improvements were needed in areas such as delayed transfers of care and critical care capacity. The Faculty of Intensive Care Medicine had also highlighted a lack of critical care capacity, and there were reports of patients being unable to be transferred to a tertiary centre due to lack of critical care bed capacity. To help address these issues, the Welsh Government established a nationally directed programme for critical care in 2018 which included £15 million additional funding for critical care services in Wales from 2019-20, plus £5 million in 2018/2019 to strengthen all aspects of critical care and help redesign the way critical care services in Wales are delivered. To assist with developing a national model for critical care and provide advice on the allocation of funding, the Welsh Government

established a task and finish group chaired by the Deputy Chief Medical Officer for Wales. I exhibit a copy of the group's report dated July 2019 at **JPM3WGO02/32a - INQ000466422[27].**

214. As a result of a review of critical care responses following the flu pandemic, critical care escalation guidance was developed in December 2016 to support Local Health Board planning and is exhibited at **JPM3WGO02/32b - INQ000469291**. This guidance stated that:

> *"Health Boards must demonstrate clearly that their arrangements for critical care escalation meet the requirements of this guidance. Each health board and critical care and trauma network region needs to assure themselves that they have plans in place to respond swiftly to such demand for services. Those plans need to take into account this guidance and major incident guidance, and include business continuity plans. In addition, health boards must ensure they have a robust plan in place for the resuscitation/ stabilisation of critically ill children and where necessary the provision of ongoing paediatric critical care whilst awaiting for arrival of the specialised transport service or where capacity issues mean a PICU bed is unavailable for a prolonged period."*

215. I am also aware of concerns about the NHS estate, particularly regarding suitable isolation facilities which I have outlined in the section of this statement regarding implementation of Infection and Prevention Control ("IPC") measures, and there were concerns that older estate would impede some aspects of Infection and Prevention Control compliance, such as deep cleaning.

216. I do not think the Welsh Government would ever have foreseen or anticipated the need to respond to a pandemic situation of the level and consequence of the Covid-19 pandemic, however there was significant work in Wales to improve peacetime services and build resilience into the system. The Welsh Government's 'A Healthier Wales' plan, exhibited at **JPM3WGO02/33 – INQ000066130,** outlines a vision for the health and social care sector, emphasising well-being and illness prevention. It includes the following key points:

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[27] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000484885]

a) **Integrated Services**: The plan aims to support health and social care services work together to deliver care seamlessly to patients and service users. Collaboration with other sectors like the third sector education and housing was also prioritised with a focus on services working together to meet the needs of individuals and communities.

b) **Home-Based Care**: the plan included efforts to provide more care at home or as close to home as possible. This shift away from hospital-centric care to more community-based care was intended to promote independence and well-being.

c) **Prudent Healthcare**: Inspired by the philosophy of prudent healthcare, the plan focuses on higher quality care through less intensive clinical interventions, reduced variation, waste, and harm.

217. In summary, A Healthier Wales seeks to keep people healthy, independent, and well-supported within their communities only going to hospital when needs cannot be met through community and home-based care.

Chronology of capacity throughout the pandemic

218. 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.

219. Bed capacity data was submitted by Local Health Boards and Velindre NHS Trust on data proformas to Digital Health and Care Wales. It was 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.

220. The daily sitrep spreadsheet reports presented data on an all-Wales level as well as allowing a breakdown by each Local 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. The data would have included those beds with an oxygen supply as part of the global figures but did not distinguish between those beds which did have an oxygen supply (e.g. for patients requiring

CPAP) and those which did not. Whilst not included in the initial sitreps, the sitreps later included information on oxygen devices available and in use. 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.

221. As detailed in paragraphs 428 to 432 of the corporate statement for the Health and Social Services Group (reference M3-WGO-01), and also set out later in this statement, Dr Andrew Goodall wrote to Local Health Boards on 4 April 2020 to discuss capacity plans and outline the levels of additional critical and acute beds that they were targeting to bring online in order to meet the reasonable worst case scenario. A copy of the letter was exhibited in **JPM3WGO02/33a - INQ000227011.** He also wrote to Local Health Boards again on 24 April 2020 confirming approaches to continuing, reducing or even halting work on additional bed capacity due to actual demand being less than originally planned.

222. The number of additional surge beds that may need to be made operational was then 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.

223. To assist healthcare professionals to manage surge capacity, the Pandemic Influenza: Extreme Surge Guidance for the NHS in Wales guidance was updated for Covid-19 by the Covid-19 Health and Social Services Planning and Response Group in April 2020, as exhibited in **JPM3WGO02/33b - INQ000253848**[28] and set out in further detail later in this statement. This guidance was drafted as a contingency and never needed to be implemented during the relevant period.

224. 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 occupancy.

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

225. The Welsh Government retains 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 relevant data has been included in the corporate statement of the Health and Social Services Group (reference M3-WGO-01).

226. The Inquiry has asked whether any Local Health Boards experienced full occupancy in hospital wards or in critical care or came close to reaching full capacity during the relevant period. In general terms, there were periods during the relevant period when capacity was significantly stretched across hospitals in Wales but that any such issues were managed via mutual aid between Local Health Boards (see paragraphs 526 to 534 of the corporate statement of the Health and Social Services Group, reference M3-WGO-01, which sets out the guidance relating to mutual aid, and examples of mutual aid having been relied on). Notwithstanding that, the Welsh Government is not aware of any occasions during the relevant period where that critical care or general bed capacity was ever reached or exceeded but Digital Health and Care and Wales would be best placed to confirm this information for individual hospitals or Local Health Boards.

Bed availability (capacity) and hospital admissions

227. Dr Andrew Goodall has explained, and illustrated, the available beds by Covid-19 designation from March 2020 to June 2022 at paragraphs 422 – 446 of the corporate statement of the Health and Social Services Group (reference: M3-WGO-01) as well as the number of hospital admissions for Covid-19 and non-Covid-19 conditions for the same period. Dr Andrew Goodall is best placed to elaborate on and explain those statistics. For the Welsh Government, the data did not inform operational decisions but, by focusing on overall bed capacity and Covid-19 status, provided a picture of the development of the pandemic and the effect on healthcare services to inform the broader decisions being taken at a government level.

Critical care bed availability (capacity)

228. Dr Andrew Goodall has explained and provided data relating to the Critical Care bed availability in Wales from April 2020 to June 2022 at paragraphs 447 - 451 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01).

229. The daily available invasive ventilated (critical care) beds peaked at over 400 in April 2020. The numbers fell back and stabilised between 200 and 250 from early 2021. The Additional critical care capacity was created within existing NHS hospital sites (which already had critical care provision) in general on wards adjacent to existing critical care units or areas such as theatre recovery. One Local Health Board built a temporary critical care decant area within their outpatients department. The number of critical care beds required had reduced due to the actual number of beds being less than planned following the first wave and the move to local assessments to determine actual levels as previously exhibited in **JPM3WGO02/33a - INQ000227011.**

230. Until 13 November 2020, all 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'.

231. 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.

Critical care admissions (occupancy)

232. Dr Andrew Goodall has provided the data for the number of critical care admissions at paragraphs 452 – 458 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01).

233. As noted above the Welsh Government did not receive and does not hold any data in relation associated resources in terms of appropriately staffed beds and medical equipment available to NHS hospitals. This information would have been held locally by individual Local Health Boards and the NHS Wales Shared Services Partnership.

Concerns regarding bed capacity

234. The Inquiry has asked for details of any incidents or occasions during the relevant period where there were concerns that demand might imminently exceed bed capacity in Wales. As set out earlier in this statement, at no point were bed capacity limits breached in Wales. The highest overall occupancy across Wales at that time.

It was reached in June 2022 and includes critical care, acute level, field hospitals, private hospitals and community hospital beds.

235. The table below shows the available bed capacity levels reached for each Local Health Board on 30 June 2022. The relevance and significance of these statistics is very dependent upon a number of factors, including the organisation and the type of services it provides, the size of the organisation and the population it serves. As the Inquiry is aware, June 2022 did not represent a significant Covid-19 peak and data suggests that cases of Covid-19 were at that time declining. The occupancy described below cannot be attributed to Covid-19 patients. By June 2022 the declining Covid-19 rates and increasing vaccination levels allowed the NHS in Wales to plan for higher levels of emergency and elective activity.

Table 7: Table showing percentage of bed occupancy amongst Local Health Boards on 30 June 2022

Local Health Board	**Percentage of bed occupancy on 30 June 2022**
Aneurin Bevan University Local Health Board	98%
Betsi Cadwaladr University Local Health Board	94%
Cardiff & Vale University Local Health Board	91%
Cwm Taf Morgannwg University Local Health Board	97%
Hywel Dda University Local Health Board	97%
Powys Teaching Local Health Board	87%
Swansea Bay University Local Health Board	93%
Velindre University NHS Trust	70%
Total	**94%**

Concerns relating to portable oxygen supplies or medical gas pipeline systems

236. The Acute Secondary Care Planning and Response Sub-group remit included oversight of portable oxygen supplies or medical gas pipeline systems in acute hospitals in Wales during the relevant period. A copy of this sub-group's terms of reference and membership is exhibited in **JPM3WGO02/34 - INQ000226959.** In March 2020 this subgroup undertook an assessment of available invasive and non-invasive ventilation devices such as ventilators and Continuous Positive Airway Pressure ("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 **JPM3WGO02/35 - INQ000226972.**

237. Responses were collated by the Critical Care and Trauma Network of the NHS Wales Collaborative. The Critical Care Network did not share the individual information received from Local Health Boards but provided a collated update. The initial collated update on 31 March 2020 is exhibited at **JPM3WGO02/35a-INQ000226996.** There was no target for the number of devices required and the expected figures were based on the number of devices thought to be available for procurement activity at that time. This was during a period of the pandemic when it was not known if the Non-Pharmaceutical Interventions would be effective in reducing demand for invasive or non-invasive ventilation.

238. In summary there were 202 invasive devices already deployed and 35 in store at the Shared Services Partnership. There were also 861 other devices (not CPAP) that could be repurposed, but may not all be suitable. Additionally, there were 1098 CPAP devices, which could be used in critical care but would more likely be used on Covid-19 cohort wards.

239. The NHS Wales Shared Services Partnership led the procurement of additional ventilation devices and reported procurement activity to the Sub-group.

240. Details of newly procured ventilators were collated from 1 April 2020 until 7 May 2020 in the Ventilator and Associated Equipment Daily Reports. The report for 7 May 2020 which contains the collated information throughout the period, is exhibited at **JPM3WGO02/35b - INQ000484920.** This report reflects the following data for expected additional quantities of ventilator equipment against actual additional quantities received as outlined below. The lower numbers received compared to the expected quantity reflects the delay in devices arriving in stock at the time. There were no significant consequences of the lower number of items received as functional capacity was not exceeded.

Table 8: Table showing expected additional quantities of ventilator equipment against actual additional quantities received

Equipment type	Expected additional quantity	Actual additional quantity
Oxygen Concentrators	261	228
BiLevel Ventilators	414	233
Mechanical Ventilators	956	225
Continuous Positive Airway Pressure (CPAP) High Flow Prototype	684	382

241. Any offers of support or new supply received via officials or ministers were passed onto the NHS Wales Shared Services Partnership to investigate and where appropriate action. The Sub-group 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.

242. The Welsh Government worked directly with NHS Wales Shared Services Partnership Specialist Estates Services and the British Oxygen Company ("BOC") 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 Local Health Boards were requested on the 9 April 2020, exhibit **JPM3WGO02/36 - INQ000262275**[29] outlines the summary position in Wales at the time which is reproduced this below in ease of reference:

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

Table 9: 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

243. It is my understanding that the Royal Engineers involved worked closely with NHS Wales Shared Services Partnership-SES and BOC in agreeing a clear plan of action to support the drive to build capacity in the NHS. The Welsh Government does not hold the dates during which such co-working occurred as they would be held by individual health organisations. A copy of a report dated June 2020 prepared by the NHS Wales Shared Services Partnership which outlined how the Welsh Government, NHS in Wales and BOC responded to the challenge of oxygen capacity and distribution in Wales is exhibited in **JPM3WGO02/37 - 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 the NHS in 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 some major challenges. The dates on which the delivery of the increased oxygen

capacity at each individual site are not held by the Welsh Government. 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 were 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 Welsh Government is unable to confirm whether all of the recommendations were implemented but is able to confirm that the Welsh Government asked the NHS Wales Shared Services Partnership-SES to take a lead role in strengthening the oxygen infrastructure across the NHS in Wales, as noted in a Specialist Estates Services Notification dated 28 September 2020 exhibited at **JPM3WGO/37a – INQ000480728**. As set out in that Notification, NHS Wales Shared Services Partnership-SES established the role of Regional Estates Lead (Oxygen) to deal specifically with the challenges of Covid-19, and also proposed the establishment of an Estates Oxygen Delivery Board to support the Lead with the identification, planning and monitoring of the delivery of improvements in the life critical oxygen infrastructure in preparation of future Covid-19 surges.

Availability in Wales of particular medicines or drugs

244. The disruption to global supply chains caused by the pandemic (caused by factors such as increasing demand, a reduction in manufacturing capacity and restrictions placed on the export of medicines) created a general pressure on the availability of medicines, most notably those used in the management of patients requiring ventilation in critical care (e.g. anesthetics) and end-of-life care. Whilst there were occasions where it was necessary in hospitals for the NHS to use different preparations within a therapeutic class to those routinely used, the Chief Pharmaceutical Officer for Wales, Andrew Evans, who has assisted me with this section of this statement, has confirmed he was not aware of any situations where the preferred preparation or a clinically suitable alternative preparation with the same therapeutic effect, was not available.

245. On 9 March 2020 the Chief Pharmaceutical Officer for Wales wrote to Local Health Board, NHS Trusts, general practitioners and community pharmacies describing the

measures the Welsh Government was taking alongside the UK Government to ensure ongoing supply of medicines in response to the ongoing novel coronavirus outbreak. A copy of the letter is exhibited at **JPM3WGO02/38 – INQ000231297**. These measures included asking manufacturers to retain any medicine stockpiling arrangements that were put in place in preparation for EU exit, and requiring GPs and community pharmacists to continue to act responsibly and consider the potential consequences for patients that might arise from taking any local action that might adversely affect the medicine supply chain.

246. On 13 March 2020, the UK Government stood up the National Supply Disruption Response confirming the actions that suppliers were to take in the event of supply disruption. I exhibit a copy of the email dated 12 March 2020 at **JPM3WGO02/39 – INQ000469815** in which the UK Government sought comments from the Welsh Government on its plans to stand up the National Supply Disruption Response. I also exhibit a copy of the letter sent from the UK Government to stakeholders on 13 March 2020 at **JPM3WGO02/40 – INQ000049616**[30] in which it states that the Department for Health and Social Care was standing up the National Supply Disruption Response to monitor the supply situation and provide resolution. The letter outlines the actions suppliers were to take in the event of a supply disruption, which included doing everything possible to remedy the issue with normal supply arrangements when to contact the National Supply Disruption Response if a disruption incident could not be resolved.

247. On 19 March 2020, following a meeting with Chief Pharmacists from every Local Health Board and NHS Trust in Wales, the Welsh Government commissioned the All-Wales Therapeutics and Toxicology Centre to provide daily stock reports for 120 medicinal products used in critical care for every hospital. Exhibit **JPM3WGO02/41 – INQ000231265** provides the email exchange between officials in the Welsh Government's primary care team relating to this.

248. The Chief Pharmaceutical Officer for Wales did receive queries from clinicians relating to the use of medicines for the prophylaxis and treatment of Covid-19, whether taking some medicines increased the risk of severe illness from Covid-19, and the ongoing management of a range of health conditions affected by changes to the way care was being delivered. The Chief Pharmaceutical Officer for Wales

[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 [INQ000469820]

commissioned the All-Wales Therapeutics and Toxicology Centre to develop the Covid Therapeutic hub providing a single place to visit for evidence-based information on the therapeutic management of Covid-19 and other health conditions during the pandemic. The hub went live on 25 March 2020.

249. On 6 April 2020 Chief Pharmaceutical Officer for Wales wrote to Local Health Boards to explain the measures put in place to maximise the availability of priority medicines used in the ventilation of patients. A copy of the circular is exhibited in **JPM3WGO02/42 – INQ000231332.** The circular confirmed the range of measures which were being put in place to support efforts across the NHS in Wales to maximise the availability of priority medicines along with other medicines used in critical and palliative care. These arrangements included:

a) Arrangements to understand on a daily basis, the quantity of the stock of the priority medicines in hospitals and how many ventilated patients those stocks could support;

b) Work led by the Royal College of Anesthetists to produce a standard formulary and to minimise waste of first line and alternative treatments;

c) Coordinated production of a standardised range of central intravenous additive (CIV) products aligned to the standard formulary; and

d) Asking each Local Health Boards and Velindre NHS Trust to participate in Wales wide arrangements which supported 24/7 rapid deployment of critical care and palliative care medicines across sites within and between Local Health Board areas.

250. The effectiveness of these measures was dependent on the full cooperation of Local Health Boards in Wales. The constraints on supply of critical care medicines and implications for critical care capacity was also set out in a briefing prepared by the Chief Pharmaceutical Officer for Wales dated 16 April 2020 which I exhibit at exhibited at **JPM3WGO02/43 – INQ000469823**. This briefing highlights the mitigating actions to assist with the challenges associated with the availability of critical care medicines, including effective supply chain management, identifying clinical alternatives, reducing waste of critical care medicines and creating new supply routes.

251. As regards end-of-life care medicines, the general approach to ensuring availability of end-of-life medicines on an anticipatory or "just in case" basis was amended to ensure those medicines were available "just in time". This ensured people who needed end-of-life medicines had prompt access to them and minimised the amount of stock held in people's homes, which was not necessarily or immediately needed. The actions taken to improve availability of end-of-life medicines were:

    a) Introducing a standardised "Just in Time Emergency Medicine Pack" prepared by hospital pharmacy departments containing five injectable medicines and water for injections, essential for effective end-of-life care.

    b) The introduction in early April 2020 of the End-of-Life Covid-19 Medicines Service providing emergency access to an initial Just in Time Emergency Medicine Pack within two hours of an order being placed in or out of hours. I exhibit a copy of a document issued by the Welsh Government outlining the process of how to access end-of-life medicines which includes reference to the End-of-Life Covid-19 Medicines Service at **JPM3WGO02/44 – INQ000469830.**

    c) Ensuring every emergency ambulance and Clinical Team Leader Response Car operated by the Welsh Ambulance Services NHS Trust was equipped with a Just in Time Emergency Medicine Pack.

    d) Actions were also taken to purchase additional syringe drivers in anticipation of the increase in deaths and the need for symptom control in end-of-life care.

252. On 30 April 2020, to further improve supply of end-of-life medicines the Chief Pharmaceutical Officer for Wales issued a Welsh Health Circular permitting the reuse of end-of-life medicines prescribed for patients in care homes and hospices by other patients at the home or hospice. I exhibit a copy of the Welsh Health Circular at **JPM3WGO02/45 - INQ000231284.**

253. In June 2020, the Welsh Government published a guidance document which provided a framework within which NHS organisations could consider how availability of medicines impacted on plans for routine care. It sets out that where medicines were in short supply, pharmacy teams would play a critical role in ensuring competing demands were appropriately balanced to optimise medicine-related outcomes. I exhibit a copy of the guidance at **JPM3WGO02/46 – INQ000227198**, together with the letter dated 19 June 2020 sent by the Chief Pharmaceutical Officer for Wales

notifying the NHS of the publication of the guidance at **JPM3WGO02/47 – INQ000231331**.

254. A UK-wide approach to source extra supplies of critical medicines, including some medicines used in end-of-life care, was taken led by NHS England and supported by Welsh Government officials and the NHS Wales Shared Services Partnership's procurement service. This approach included introducing centrally controlled allocation of stock of some medicines across the UK aligned to critical care bed occupancy and issuing letters of intent to purchase to wholesalers and other suppliers, in April 2020. I exhibit the Ministerial Advice on this matter dated 29 April 2020 at **JPM3WGO02/48 – INQ000361554**.

255. In August 2020, following extensive work between Welsh Government officials, officials of other devolved governments, NHS England and the UK Government's Department of Health and Social Care, the Welsh Ministers agreed to participate in the establishment of a UK-wide Covid-19 stockpile comprised of 57 medicines used in end-of-life care, critical care, and the management of infections. The stockpile was established in anticipation of a significant second and subsequent pandemic wave. Stock for the stockpile began arriving in the UK in January 2021. I exhibit Ministerial Advice on the planned UK stockpile of critical Covid-19 medicines dated 12 August 2020 at **JPM3WGO02/49 – INQ000361617.**

256. During the first wave of the pandemic the main sources of data and statistics collected related to stock of critical care medicines (120 lines) held by every hospital in Wales. Working with experts from Local Health Boards and analysts at the All Wales Therapeutics and Toxicology Centre we were able to generate reports of daily stock holding, changes since the previous reporting period and estimates of number of days stock holding per ICU bed occupied in so called critical care dashboard. I exhibit an example of the Critical Care Medicines Dashboard of 21 April 2020 at **JPM3WGO02/50 - INQ000231322** together with the Critical Care Medicines Dashboard Explanatory Note at **JPM3WGO02/51 - INQ000231323.** The Dashboard has not been reproduced in the body of this statement as it is too large and too technical. The Dashboard captured the following information:

    a) Number of patients currently in ICU beds
    b) Maximum number of ICU beds in each Local Health Board

c) A forecast of the number of patients in ICU in the 7-day period following the report.
d) Stock available in health board pharmacies.
e) Stock needed for 5 days based on the reported ICU occupancies.
f) Packs required for next two days based on current occupancy.

257. As we entered winter, a Critical Care Medicines Position and Forecast was compiled on 28 September 2020 as exhibited in **JPM3WGO02/52 - INQ000231324.** This highlighted the impact on medicines supply of various Covid-19 wave scenarios as well as potential supply vulnerabilities within some medicine classes. The paper also set out the numbers of days stock from the 28 September 2020 of the main groups of critical care medicines which are used extensively in ventilated patients. These were:
    a) Neuromuscular blocking agents
    b) Opioid analgesics
    c) Sedatives
    d) Vasopressors

258. Throughout the pandemic the Welsh Government combined this data with ICU bed occupancy data provided by colleagues in the Welsh Government (from daily sitreps provided by Local Health Boards) to identify those medicines at greatest risk of stock outs. A copy of the 2020 Securing Adequate Supplies of Covid-19 medicines log is exhibited in **JPM3WGO02/53 - INQ000231328**. It was agreed that the Local Health Boards and Trusts would mutually support the requirement for critical medicines by any patients in neighbouring or further afield organisations by employing mutual aid when required due to medicine supply disruptions. The Medicines Supply and Mutual Aid process dated 28 September 2020 is exhibited in **JPM3WGO02/54 - INQ000231325** and outlines the process for enacting mutual aid for medicines during normal business hours and out-of-hours. This process involved the following:

    1. Pharmacy staff would enact a request for mutual aid and it will most likely be:
        a. A member of the local pharmacy procurement team for normal working hours.
        b. On-call pharmacists for out-of-hours.
    2. Assessment process.

   a. Pharmacy system highlighted “low” or out of stock position on a critical medicine.
   b. An out of stock alert received by pharmacy staff as per normal local procedures.
   c. All stock in pharmacy and other locations physically reconciled.
   d. Out of stock anticipated in 3 to 4 days or earlier.
   e. Stock requirement calculated using local demand assumptions for the next 3 to 4 days.
   f. Stock report and locations reviewed to inform the best mutual aid options by distance and volume.
3. Request process
   a. The pharmacy staff would contact the identified supplier (health board) to determine their ability to support the request for mutual aid.
   b. Any local authorisation by the supplying organisation was attained according to their local governance process e.g. sign-off by Chief Pharmacist or delegated senior pharmacist.
   c. Local Standard Operating Procedures for the purchase of medicines were followed and agreed between the requestor and supplier(s).
4. Stock movement records.
   a. Once the mutual aid was agreed both parties would ensure their pharmacy systems were updated at the appropriate time to record the transaction.
   b. The stock movement was reflected in the next data extract used for the Stock report (VAULT)
5. Transfer of Mutual Aid Stock.
   a. The requestor followed local procedures to arrange the collection and delivery of the agreed mutual aid medicines.
      i. Each Local Health Board may have had different transport arrangements.
      ii. There was HCSW T20 request form available during normal working hours.
      iii. Out-of-hours each Local Health Board had an agreed process for the transfer of medicines under their on-call SOPs.

b. The requestor once confirmed with the supplying health board agreed the date, time and location for collection of the medicine(s).
c. The transfer information was supplied to the courier who had agreed to the complete the transportation from the supplying Health Board to the requesting Local Health Board.

259. Later in the pandemic, weekly reports provided by each Local Health Board provided data on the number of non-hospitalised patients treated with Covid-19 antiviral medicines and neutralising monoclonal antibody therapies. This data was subsequently published monthly on StatsWales until March 2023. A copy of this data has been exported and is exhibited in **JPM3WGO02/55 - INQ000231298.**

<u>**Efforts to increase NHS capacity**</u>

260. The Inquiry has asked me for information about efforts to increase NHS capacity. To address these questions, I have received support from Samia Edmonds (Planning Director).

Steps taken to free up acute hospital and critical care capacity in the NHS in Wales hospitals

261. 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 scenario materialise. It was not clear at the very early stage what level of capacity was required but the likely requirement was subsequently confirmed using the UK-wide methodology developed by Imperial College, London. In March 2020, modelling for the NHS in Wales projected a necessity for 900 critical care and an additional 10,000 system-wide beds at the point of peak demand. This scenario was based on version 2.3 of the NHS in Wales modelling data which showed a 40% reasonable worst-case scenario and, given the then rate of transfer, it was anticipated that Wales would see peaks in demand over the following 3-4 weeks. This position was also informed by the experiences that were being seen in Italy and Spain who were tracking several weeks ahead of the UK at the time. Accordingly, there was a clear need to build capacity in the NHS in Wales.

262. On 13 February 2020, the Chief Medical Officer for Wales wrote to Local Health Boards, which I exhibit at **JPM3WGO02/56 - INQ000227377**. In his letter, the Chief

Medical Officer for Wales highlighted the need to increase capacity across the NHS estate to manage possible Covid-19 patients who required admission, and the need for isolation facilities and an appropriately trained workforce.

263. The letter sent by the Chief Medical Officer for Wales also requested a summary from each Local Health Board on their preparedness to be submitted by the end of the month. A summary of the returns received indicating the number of isolation bed available was prepared on the 5 March 2020 and is exhibited in **JPM3WGO02/57 - INQ000226922.**

264. The Inquiry has asked me to confirm whether the Welsh Government asked the Local Health Boards to provide details of the number of critical care and general acute beds. This did not form part of the request from the Chief Medical Officer (Wales) on 13 February 2020, however I am aware from paragraph 523 of the corporate statement of Health and Social Services Group (reference M3-WGO-01) that there were approximately 152 level 3 equivalent critical care beds in Wales as of 1 March 2020. I exhibit a copy of a letter sent from Dr Andrew Goodall to the Chief Executives of the Local Health Boards on 20 March 2020 at **JPM3WGO02/57a – INQ000252594**[31] asking for data on bed capacity to be provided for the purposes of providing advice to the Welsh Government to make decisions about responding to the pandemic.

265. As set out above, this data formed part of the sitreps which were introduced from 23 March 2020, but the data remained incomplete until 29 March 2020. Daily sitreps on bed capacity containing full datasets for NHS hospitals were available from 30 March 2020. Due to the way data was being recorded at the time, community or private hospital data were not included. Data on bed capacity on 30 March 2020 showed:

a) Total critical care beds available 304 with 113 beds (37%) occupied.

b) Total acute beds available 6918 with 3600 beds (53%) occupied.

c) Total designated Covid-19 acute beds available 1316 beds with 465 (35%) occupied.

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[31] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000484892]

266. At a conference call on 11 March 2020 with the Chief Executives of each of the Local Health Boards across Wales, Dr Andrew Goodall asked each Local Health Board to provide an update on their options, and if available plans, to free up capacity in preparation for an increase in Covid-19 demand. I previously exhibited the responses of:

a) Cardiff and Vale University Health Board dated 11 March 2020 at **JPM3WGO02/04a - INQ000479914** and **JPM3WGO02/04b - INQ000479916**.

b) Aneurin Bevan University Health Board dated 12 March 2020 at **JPM3WGO02/04c** – **INQ000479921**.

c) Hywel Dda University Health Board dated 12 March 2020 at **JPM3WGO02/04d** – **INQ000283251**.

d) Powys Teaching Health Board dated 12 March 2020 at **JPM3WGO02/04e** – **INQ000479915**.

e) Cwm Taf Morgannwg University Health Board dated 12 March 2020 at **JPM3WGO02/04f** - **INQ00047992**0.

f) Betsi Cadwaladr University Health Board dated 12 March 2020 at **JPM3WGO02/04g** - **INQ000479922**.

g) Swansea Bay University Health Board dated 12 March 2020 at **JPM3WGO02/04h - INQ000484912**.

267. As set out in responses, a number of actions were being undertaken to free up capacity within the existing hospital estate such as by re-purposing areas for use by Covid-19 patients. For example, in the response returned from Aneurin Bevan University Health Board (which I prepared in my capacity as Chief Executive of Aneurin Bevan University Health Board at that time), I indicated that we were securing a safe area for Covid-19 assessment of sick patients by moving the Minor Injuries Unit into the main outpatients/fracture clinic, which gave three dedicated rooms plus six curtained areas to which we fit doors to safely isolate on attendance.

268. A key theme arising from the responses received was the need to reduce non-urgent surgery and related activities in order to free up staff and beds in order to increase capacity. Taking into consideration the responses received from the Local Health Boards in increasing capacity, the Minister for Health and Social Services issued a written statement on 13 March 2020 which I exhibit at **JPM3WGO02/58 - INQ000320755** setting out a framework of actions allowing services and beds to be reallocated and for staff to be redeployed and retrained in priority areas. These actions are already set out at paragraph 459 of the corporate statement of the Health and Social Services Group but for completeness, I have set them out again below:

1. Suspend non-urgent outpatient appointments and ensure urgent appointments were 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 protocol which gave the right to a choice of home.
8. Permission to cancel internal and professional events, including study leave, 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.

Additional step-down capacity was also created in Local Health Boards by the use of community hospitals, private hospitals and field hospitals, set out below.

269. The Welsh Government was very active to ensure that they were implemented to help in maintaining adequate capacity within the healthcare system. This is illustrated in the letter sent on behalf of Dr Andrew Goodall on 14 March 2020 to

the Chief Executives of the Local Health Boards, NHS Trusts and Health Education and Improvement Wales, and the Director of NHS Wales Shared Services Partnership which I exhibit at **JPM3WGO02/59 – INQ000182429**[32]**.** In that letter Dr Andrew Goodall asked the NHS bodies to submit plans by 17 March 2020 indicating how each organisation will implement, or support implementation, of each action (as applicable). I exhibit the responses of:

a) The Welsh Ambulance NHS Trust dated 16 March 2020 at **JPM3WGO02/59a – INQ000361369**[33].

b) Velindre University NHS Trust dated 18 March 2020 at **JPM3WGO02/59b – INQ000271415**[34]**.**

c) Public Health Wales dated 18 March 2020 at **JPM3WGO02/59c - INQ000056346**[35] - **JPM3WGO02/59d - INQ000191814**[36], **and JPM3WGO02/59e - INQ000383930.**

d) Health Education and Improvement Wales dated 18 March at **JPM3WGO02/59f – INQ000484908**.

e) Powys Teaching Health Board dated 18 March 2020 at **JPM3WGO02/59g–INQ000479927** and **JPM3WGO02/59h – INQ000479926**.

f) Swansea Bay University Health Board dated 18 March 2020 at **JPM3WGO02/59i – INQ000252811**[37].

g) Betsi Cadwaladr University Health Board dated 18 March 2020 at **JPM3WGO02/59j – INQ000484903**.

h) Cwm Taf Morgannwg University Health Board dated 18 March 2020 at **JPM3WGO02/59k – INQ000484893**.

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[32] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000227112]
[33] 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 [INQ000484909]
[34] 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 [INQ000480047]
[35] 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 [INQ000383928]
[36] 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 [INQ000383929]
[37] 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 [INQ000484902]

i) Hywel Dda University Health Board dated 18 March 2020 at **JPM3WGO02/59l – INQ000484894**.

j) Aneurin Bevan University Health Board dated 18 March 2020 at **JPM3WGO02/59m – INQ000484906**.

k) Cardiff and Vale University Health Board dated 18 March 2020 at **JPM3WGO02/59n – INQ000484910**.

270. As the pandemic developed the Welsh Government continued to work closely with the NHS to ensure that there remained adequate capacity within the healthcare system. On 4 April 2020, Dr Andrew Goodall wrote to the Local Health Boards setting out how many additional critical care and acute beds were required at each Local Health Board based on the 40% reasonable worst case scenario approach. I have previously exhibited a copy of the letter dated 4 April 2020 at **JPM3WGO02/33a - INQ000227011,** and I have provided a copy of the table setting out the number of additional beds required below. As outlined in the letter, the target we were trying to achieve for Wales was to accommodate the reasonable worst-case scenario which predicted the total critical care capacity and additional acute capacity as outlined in the table below. The 40% reasonable worst-case scenario 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. As set out at paragraph 429 of the corporate statement of the Health and Social Services Group (reference: M3-WGO-01), the number of target number of additional beds required in each Local Health Boards was not a blanket percentage increase 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.

Table 10: Table showing the number of additional beds required for the reasonable worst-case scenario (RWC)

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

271. The Local Health Boards were asked to report on progress against these targets in order to collectively understand how close they were getting to delivering on those targets in the 3-4 week timescale and to understand any local constraining factors to increase capacity. I exhibit of the responses of:

a) Cardiff and Vale University Health Board dated 6 April 2020 at **JPM3WGO02/59p - INQ000484911**.

b) Betsi Cadwaladr University Health Board dated 6 April 2020 at **JPM3WGO02/59q - INQ000484814**.

c) Hywel Dda University Health Board dated 6 April 2020 at **JPM3WGO02/59r - INQ000484904**.

d) Powys Teaching Health Board dated 6 April 2020 at **JPM3WGO02/59s - INQ000484817**.

e) Aneurin Bevan University Health Board dated 6 April 2020 at **JPM3WGO02/59t - INQ000399800**[38] and **JPM3WGO02/59u - INQ000399801**[39].

f) Swansea Bay University Health Board dated 6 April 2020 at **JPM3WGO02/59v - INQ000252774**[40].

g) Cwm Taf University Health Board dated 7 April 2020 at **JPM3WGO02/59w - INQ000484905**.

272. As set out in the corporate statement of the Health and Social Services Group (reference M3-WGO-01), information on the responses provided by Local Health Boards was summarised for the Minister for Health and Social Services on 8 April 2020 as set out in the briefing exhibited in **JPM3WGO02/60- INQ000352986.** In that briefing it was noted that there was 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 of the expected number of beds being made available:

Table 11: Table showing the expected number of beds being made available

[38] 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 [INQ000484819]

[39] 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 [INQ000484820]

[40] 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 [INQ000484816]

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

Field Hospitals and Private Hospitals

273. As indicated in the table set out above, much of the additional capacity was to be achieved via the creation of field hospitals and the use of the private sector.

274. Neither field hospitals nor private healthcare contributed critical care or acute care to Covid-19 patients. 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. 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 Digital Health and Care Wales would be better placed to provide this information as data owners.

275. Further information on:

    a) The use of field hospitals is set out at paragraphs 488 to 521 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01). As set out at paragraph 499 of that statement, the operational control and decision making in relation to field hospitals (such as the decision to establish a field hospital and staffing matters) rested with individual Local Health Boards, but the Welsh Government provided support for the use of field hospitals as a means of increasing capacity through the approval of funding.

    b) The use of the private healthcare sector is set out at paragraphs 538 to 551 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01). As with field hospitals, the use of the private healthcare sector remained a matter for individual Local Health Boards, but as noted at paragraph 539 of that statement the Welsh Government supported the NHS in obtaining the flexibility to utilise the private sector by providing financial support and also supporting facilitation of the arrangements at pace by requesting the Secretary of State to disapply Competition Act restrictions.

276. The above table also references the Grange as a new hospital facility which was anticipated to provide up to 350 additional beds to support the increase of NHS capacity within Aneurin Bevan University Health Board. The Welsh Government was instrumental in supporting the opening of the Grange, and thereby increasing capacity within the local area by agreeing to the early handover to Aneurin Bevan

University Health Board, and a copy of the ministerial advice relating to that is exhibited at **JPM3WGO02/60a - INQ000144857.**

277. Accordingly, whilst it remained the responsibility of each individual Local Health Board to undertake the necessary steps to increase capacity to meet the needs of its local area during the pandemic, the Welsh Government was highly instrumental in supporting and facilitating the needs of the Local Health Boards to ensure that adequate capacity was achievable at the local level and thus overseeing capacity on a system-wide basis. The combination of the work undertaken to increase capacity, both by the Welsh Government and by the NHS in Wales, was highly effective in increasing critical care capacity in acute hospital and crucial care capacity.

278. The additional capacity created in field hospitals was not required at the level that was initially anticipated with thanks to the success of measures taken to manage the outbreak of Covid-19 - including 'lockdown', social distancing and shielding of vulnerable people. A high-level paper was compiled and reflected on the planning, development and delivery of field hospital facilities as of June 2020 and the direction of travel for their use, based on the latest available predictive data modelling for future, exhibited in **JPM3WGO02/61 - INQ000227392**. The initial planned field hospital capacity in Wales as detailed in Annex 1 of that report is set out in the following table.

Table 12: Table showing the initial planned field hospital capacity in Wales

HB > field hospital / surge facility	**Estimated planned capacity**
Aneurin Bevan	**384**
Grange University Hospital (initially planned as an interim facility if required)	384
Betsi Cadwaladr	**1,010**
Ysbyty Enfys Bangor	223
Ysbyty Enfys Llandudno	351
Ysbyty Enfys Deeside	436
Cardiff & Vale	**1,500**
Dragon's Heart Hospital	1,500

Cwm Taf Morgannwg	**775**
WRU Hensol	255
Bridgend	450
Marsh House (Merthyr)	85
Abergarw Manor (Bridgend)	85
Hywel Dda	**1,033**
Parc Y Scarlets Barn	276
PYS Stadium	92
LLaneli LC	154
Selwyn Sam Centre	143
Carmarthen LC	93
Bluestone	124
Cardigan Leisure Centre	48
Plas Crug Aberystwyth LC	52
Penweddig School	51
Powys	**78 - 90**
Royal Welsh Showground (provisionally considered but stood down)	78 - 90
Swansea Bay	**1,279**
Llandarcy Field Hospital	316
Bay Field Hospital	963
All Wales	**6,071**

279. The planning response to identify and secure premises and equip field hospitals with 6071 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. It also noted the fact that field hospitals had not been required and generally remained empty to that date should be viewed as a positive given the reasonable worst-case scenario had suggested Wales requiring up to a further 10,000 beds to avoid becoming over-burdened if mitigating actions did not have the desired effects. Due to the way that the data is recorded, as data owners, Digital Health and Care Wales are best placed to confirm the actual capacity achieved.

280. In summary:

a) The introduction of field hospitals and steps to make beds in community hospitals and care homes available, created additional beds for step down care. However, as the use to which those beds may be put would vary throughout the pandemic, it will not be possible to produce a simple figure of increase in steps down beds.

b) The use of private hospitals provided capacity for non-Covid-19 treatment. Those private hospitals may have provided critical care to non-Covid-19 patients, which in turn released capacity within NHS hospitals, but the number of beds put to that use within private hospitals is not available.

281. The additional capacity created within the system was ultimately not required during the first wave of the pandemic. In a letter dated 24 April 2020 exhibited at **JPM3WGO02/62 - INQ000395661**, Dr Andrew Goodall indicated that he remained content that there was considerable amount of additional capacity within the system and endorsed a position where we did not commission and operationalise that capacity unless it was needed.

282. In a letter dated 28 July 2020 to the Chief Executives of the Local Health Boards and exhibited at **JPM3WGO02/63 - INQ000227245**, the Deputy Chief Medical Officer for Wales and the Nursing set out a summary of the critical care response to the first wave. Further information on the critical care provision in Wales during the first wave was set out in an annex to the letter which I exhibit at **JPM3WGO02/64 - INQ000227233** and noted that at no point during the first wave did the Welsh Government breach the available capacity.

283. I have set out below for the first, second and third waves of the pandemic the date on which the total occupancy was highest, with the related overall critical care capacity available on that date. The figures in the table below have been calculated using the sitrep data provided by Local Health Boards.

Table 13: Table showing the date on which the total occupancy was highest during the first, second and third waves of the pandemic

Time period	Date of peak occupancy	Overall critical bed capacity	Total critical care occupancy	Covid Critical Care Occupancy
1st wave	17/04/2020	399	216	159
2nd wave	10/01/2021	264	234	144
3rd wave	9/11/2021	229	195	73

284. Key principles on preparing for a second wave was set out in a further annex to the letter dated 28 July 2020 which I exhibit at **JPM3WGO02/64a - INQ000227232.** As set out in that letter, the Local Health Boards were asked to:

a) Undertake a lessons learned review of how critical care has been operating since the outbreak.
b) Ensure there is appropriate well-being/mental health support available for all staff who have worked within the critical care environment during the Covid-10 outbreak.
c) Review existing plans for critical care escalation to ensure they are fit for purpose (including consideration of revised staffing levels/ratios).
d) Consider what capacity can be retained in the short-medium term (suggested capacity 150%).
e) Review existing critical care arrangements within the health board.
f) Provide confirmation of the ventilator position and set out any requirements for additional ventilators (if required).
g) Confirm the arrangements in place to maintain critical care competencies (for those who do not normally work within critical care).
h) Ensure plans were in place to reach 200% capacity within ideally 7 days, but a maximum of 14 days.
i) Undertake a readiness assessment before resuming routine surgery.
j) Ensure appropriate pathways are developed to meet rehabilitation/follow-up requirements for patients following treatment in critical care for Covid-19.
k) Work with the Wales Critical Care and Trauma Network/NWIS to foll out the critical care information system across Wales.

285. Information setting out the lessons learned from the second wave of the pandemic was circulated by the Wales Critical Care and Trauma Network on 10 August 2021,

and is exhibited at **JPM3WGO02/65 - 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.

286. Dr Andrew Goodall has set out in the corporate statement of the Health and Social Services Group (reference M3-WGO-01) at paragraphs 535 to 537 the limiting factors experienced by the Welsh Government in expanding critical care capacity. This included staff skill mix, staff absence, training, ancillary equipment, oxygen delivery/consumption, and shortages of drugs. As set out in that statement, despite these limitations 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 unit. I have been asked to address the mechanism by which the Welsh Government would have been made aware if such circumstances had ever arisen in a Welsh hospital or Local Health board:

a) Such circumstances would have triggered implementation of the Extreme Surge Guidance. This guidance, which is described below and in more detail

in the corporate statement of the Health and Social Services Group (reference M3-WGO-01), was never required to be implemented.

b) My predecessor Dr Andrew Goodall, as well as many other Welsh Government officials, were in very regular contact with Local Health Boards and would certainly have been made aware of any such circumstances occurring.

Intensive or critical care rationing

287. Prior to the outset of the Covid-19 pandemic, the Welsh Government had previously prepared a draft Extreme Surge Guidance for the NHS in Wales in order to support local pandemic preparedness and response in the event of a surge in demand for critical care. I exhibit "Pandemic Influenza: Extreme Surge Guidance for the NHS in Wales" at **JPM3WGO02/76 – INQ000252542**, which 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 at **JPM3WGO02/77 – INQ000116503**.

288. 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 previously exhibited in **JPM3WGO02/33b - INQ000253848.** The guidance was prepared with input from the Moral and Ethical Advisory Group, Legal Services and NHS Wales Medical Directors and emphasised the need to consider human rights and the importance of difficult decisions being based on sound and defensible ethics. In such circumstances, it also set out the framework of principles to aid good clinical decisions and the escalation process up to national level. The 'CRITCON' system of regional and national escalation and mutual aid is described in detail in paragraphs 527 to 530 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01).

289. The Extreme Surge Guidance was revised several times at points of significant operational pressures during the course of the pandemic, firstly, in January 2021, entitled "COVID-19 managing extreme surge in Wales NHS, exhibited **JPM3WGO02/78 - INQ000299731**; and December 2022, entitled, "Guidance to Support Wales NHS Response to Extreme Pressure / Surge", exhibited **JPM3WGO02/79 - INQ000300254.**

290. The Extreme Surge guidance did not include a decision-making tool for prioritisation of patients in the event of critical care demand exceeding capacity, and the Welsh Government did not develop such a tool at any point during the pandemic.

291. A draft decision-making tool which included a scoring system was shared by the UK Government and considered at the end of March 2020. Following consideration, the Chief Medical Officer and Deputy Chief Medical officer took the decision not to use the tool and advised clinicians accordingly, with concerns raised that the tool proposed could be discriminatory in nature. CMEAG Wales considered the ICU triage tools and provided comments that the tools were unsuitable to use for a different purpose for which they had been designed and validated, especially as they did not explicitly take into account broader equity considerations.

292. The All Wales Critical Care Network supported using a tool but accepted the concerns with the UK Government's proposal. The Network subsequently developed, alongside the Welsh Intensive Care Society, a different tool to help aid clinical decision-making. While not produced or developed by the Welsh Government, the draft document was shared with the Welsh Government on 9 April 2020. The Deputy Chief Medical Officer expressed his and the Chief Medical Officer's concerns about the use of a scoring table and their preference for greater emphasis on shared decision-making. In response, the Network agreed to remove the scoring system in favour of highlighting factors known to worsen outcome. The email exchange is exhibited in **JPM3WGO02/80 - INQ000484821**. The Network issued the revised tool, exhibited in **JPM3WGO02/81 - INQ000338460**[41] to NHS organisations in Wales.

293. Whilst the guidance was ultimately aimed at supporting local clinical decision making, the intention was that the triggering of the guidance should be confirmed nationally by the Chief Executive of NHS Wales, the Chief Medical Officer for Wales and the Minister for Health and Social Services. This was to ensure consistency and assurance that all other local and regional flexibilities had been exhausted. It was, however, never required to be implemented because we never reached the point where the number of people requiring treatment outweighed the resources available. The extreme surge guidance was always considered as an action of last resort as it

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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. Further detail on the Extreme Surge Guidance is set out in paragraphs 146 to 147 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01).

Steps taken to maximise NHS healthcare and support staff availability

294. The actions agreed on 13 March 2020 to pause non-urgent services as set out above were in part designed to allow for the flexible redeployment of staff to priority areas. Health Education and Improvement Wales also developed and commissioned critical care training which was made available to all Local Health Boards to support staff who were redeployed to critical care.

295. The Welsh Government also collaborated with public service partners to facilitate emergency ambulance driving training for Fire and Rescue Service 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.

296. Further information on the steps taken by the Welsh Government to increase NHS staffing levels during the pandemic is set out in the corporate statement of the Health and Social Group (reference M3-WGO-01) at paragraphs 605 - 608.

Legislation to increase or improve NHS capacity in Wales in response to the pandemic

297. The only legislation that was made by the Welsh Government and placed before the Senedd in order to directly increase or improve NHS capacity in Wales in response to the Covid-19 pandemic were the amendments made to the Town and Country Planning (General Permitted Development) Order 1995 ("the GPDO"). The GPDO confers permitted development rights in respect of certain development and thereby allowing development to be undertaken without the need to submit a planning application. The amendments to the GPDO enabled the creation of facilities to limit the spread of coronavirus, treat, test care for and manage the recovery of an

extremely high number of patients. This included field hospitals which, as referred to above, were a key part in increasing NHS capacity in Wales.

298. Legislation amending the GPDO was as follows:

a) The Town and Country Planning (General Permitted Development) (Amendment) (Wales) Order 2020 brought into force on 30 March 2020. These amendments permitted the development by a local authority on land owned, leased, occupied or maintained by it for the purposes of (a) preventing an emergency, (b) reducing, controlling or mitigating the effects of an emergency, or (c) taking other action in connection with an urgency.

b) The Town and Country Planning (General Permitted Development) (Amendment) (No. 2) (Wales) Order 2020 brought into force on 10 April 2020. These amendments inserted a new part 3A (Temporary Buildings and Changes of Use for Public Health Emergency Purposes) to permit certain development in Wales by an NHS body for the purposes of preventing, controlling or mitigating the effects of, or taking other action in connection with a public health emergency in the United Kingdom. The development permitted was the change of use of a building or land from any class in the Schedule to the Use Classes Order or any other use to Class C2 (residential institutions) or Class D1 (non-residential institutions), and the provision of buildings or other structures.

299. As regards other legislation made by the Welsh Government and laid before the Senedd, the Coronavirus Restrictions Regulations that were made under the Public Health (Control of Disease) Act 1984 and imposed restrictions on people gathering, on people travelling and on the use of premises of specified businesses or services that were ordinarily open to the public were instrumental in reducing the spread of coronavirus and ensuring that the capacity in the healthcare system did not become overwhelmed. Accordingly, as I have referred to above, such measures were helpful in improving capacity within the NHS, albeit in a more indirect manner.

Implementation of Infection Prevention and Control ('IPC') measures in healthcare settings

300. The Inquiry has asked me for information about the implementation of infection prevention and control (IPC) measures in healthcare settings. In order to address

these questions, I have received support from Professor Chris Jones (Deputy Chief Medical Officer for Wales).

Issues concerning the condition and layout of buildings in the NHS estate in Wales when implementing new IPC guidance for healthcare settings

301. When implementing IPC guidance during the pandemic the Welsh Government was aware of the challenge and potential conflict between IPC and the hospital environment.

302. The four nations public health High Consequence Infectious Disease group made an interim recommendation in January 2020 to classify Covid-19 as a High Consequence Infectious Disease. On 13 February 2020, the Chief Medical Officer for Wales wrote to all Local Health Boards asking them to address the findings of the audit of the Airborne Isolation Rooms across Wales. A copy of this letter was exhibited earlier in **JPM3WGO02/56 - INQ000227377**. The audit had noted that the current provision of isolation rooms was inadequate in terms of compliance with technical standards and the number of rooms in respect of locational requirements. The review specifically looked at compliance with the latest guidance issued by the Welsh Government – the Welsh Health Circular (2018) 033.

303. One of the main recommendations stated in Welsh Health Circular in 2018, against which the isolation facilities were measured, was that all new isolation rooms used for the isolation of patients who had infections that could be spread via the airborne route had to be Negative Pressure Suites (NPS). The circular also recommended that Local Health Boards should consider converting existing Positively Pressurised Ventilated Lobby (PPVL) isolation suites to NPS suites. Other requirements included required each Local Health Board to provide isolation rooms in the following locations:

    a) Every hospital in Wales with a 24-hour Emergency Unit must have at least one Negative Pressure Suite located within that Emergency Unit.

    b) Every Local Health Board in Wales must have at least one Negative Pressure Suite able to accommodate a case requiring respiratory isolation in either an acute respiratory unit, or an infectious diseases unit or a medical unit with access to respiratory expertise.

    c) Every Local Health Board in Wales must also have either:

i. A Negative Pressure Suite in every Level 3 general Critical Care Unit
   Or
ii. At least one Negative Pressure Suite in a Level 3 general Critical Care Unit and robust plans (agreed with all partner agencies involved) for transfer and transport of critical ill cases requiring respiratory isolation between the Critical Care Units within the Local Health Board.

d) In addition, there must be a Negative Pressure Suite in every tertiary specialist pediatric facility in Wales.

304. On 19 February 2020, the Welsh Government met with the NHS Shared Services Partnership – Specialist Estate Services to discuss the findings of the recent Audit of the Airborne Disease Isolation Rooms across Wales. Cardiff and Vale University Health Board were identified as not having facilities that met the standard required for the operation of a High Consequence Infectious Disease unit as required by the Welsh Health Circular (2018) 033. Dr Marion Lyons (Senior Medical Officer of the Welsh Government) wrote to the Chief Executive of Cardiff and Vale University Health Board on 19 February 2020 setting out the requirements for the High Consequence Infectious Disease Unit within the next 2 – 3 weeks, a copy of which is exhibited at **JPM3WGO02/84 – INQ000392269**[42]. Dr Lyons also instructed Cardiff and Vale University Health Board to convert existing Positively Pressurised Ventilated Lobby (PPVL) isolation suites to NPS suites which was also recommended in the circular. In the meantime, the expectation was that should a High Consequence Infectious Disease bed be required, it would be commissioned from one of a few High Consequence Infectious Disease providers in England. No additional funding was provided by the Welsh Government to cover these works.

305. A further email went to all Local Health Boards on 3 March 2020 specifying the issues identified in the review of isolation rooms and requesting a response from health boards as to how to they intended to address these issues. The deadline for response was close of play on 4 March 2020. By 5 March 2020 some responses had been received. These responses indicated that Cardiff and Vale University Health Board had a non-compliant adult critical care room and Cwm Taf University Health Board had 2 non-compliant isolation rooms. Time scales and costings were provided to

[42] 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 [INQ000468907]

make the rooms compliant as set out in earlier in this statement at exhibit **JPM3WGO02/57 - INQ000226922**. The summary of the returns was presented as a table which I have reproduced below for convenience:

Table 14: Summary of Local Health Board returns regarding NHS in Wales preparedness

Health Board returns to follow up email to CMO letters of 10 and 13 February 2020
COVID-19: NHS Wales preparedness

Summary		
Health Board	**Number of compliant NPS**	**Date when can accept a COVID patient**
Aneurin Bevan	4	Immediate (5/3/20)
Betsi Cadwaladr	6 adult (**awaiting clarification**) 1 neonatal	Immediate (5/3/20)
Cardiff and Vale	2 adult, 1 paediatric PPVL 1 adult room undergoing conversion to NPS, ready 9 March	Immediate PPVL (5/3/20) NPS from 10/3/20
Cwm Taf	2 PPVL	**queried**
Hywel Dda	2 NPS 2 PPVL	Immediate (5/3/20)
Powys	N/A – no acute hospitals	
Swansea Bay	2	Immediate (5/3/20)
All-Wales	15 Adult NPS 1 neonatal NPS 4 adult PPVL 1 paediatric PPVL (can accommodate 2 if necessary)	

306. As part of the overall response Cardiff and Vale University Health Board was asked by Marion Lyons, Senior Medical Officer, Public Health, to prioritise plans for the creation of a respiratory High Consequence Infectious Disease unit at University Hospital Wales. A proposal for the purchase of a modular building was submitted on 12 March 2020, and Cardiff and Vale University Health Board was given approval to secure the purchase of the Unit. However, as of 19 March 2020, Covid-19 was no longer considered to be a High Consequence Infectious Disease in the UK, so the urgency was reduced. Notwithstanding this, Ministerial Advice for the associated costs was submitted to the Minister for Health and Social Services for approval of this Unit at the end of March, as exhibited in **JPM3WGO02/85 - INQ000361815.** In the advice it noted that the decision to establish a respiratory High Consequence Infectious Disease unit was taken as a result of unprecedented pressures on the NHS and other public services in Wales. The proposal was signed off by Cardiff and Vale University Health Board Executives and endorsed by the Board. It was noted that the Local Health Board and Welsh Government officials considered this proposal at pace, without a full evidence base or access to the full range of technical advice and support normally available. It was recognised that, at the time of the initial allocation of funding, Covid-19 was classed as a High Consequence Infectious Disease and that

the increase in requirement for negative pressure isolation facilities was a consistent response by all four nations. The facility was part of the Local Health Board's Covid-19 plans, although once the classification of the disease changed the treatment of patients was also included outside of isolation rooms. The unit, however, would have a continuing potential benefit to the NHS in Wales post Covid-19 providing dedicated capacity for the treatment of acute infectious diseases when staffed. The Minister for Health and Social Services approved the establishment of this unit on 3 April 2020, and my understanding is that the unit opened on 20 May 2020.

307. When implementing IPC guidance during the pandemic, which required social distancing, bed spacing and the creation of red and green zones and pathways, the Welsh Government was aware of the challenge and potential conflict between IPC and the hospital environment, much of which estate was several years old. In Quarter 1 of 2020/21, the NHS Wales Covid-19 Operating Framework included reference to hot/cold or red/green sites, Covid-19 cohorts/zones, and dedicated isolation facilities. These zones helped manage patient pathways and allocate resources effectively, but it is acknowledged that as Covid-19 numbers increased, separation between Covid-19 and non-Covid-19 areas became more difficult, and that existing service and estate configuration made the separation of hot and cold areas difficult. The Deputy Chief Medical Officer for Wales and the Chief Nursing Officer for Wales engaged with the All Wales Medical Directors and Executive Directors of Nursing groups who explained how challenging the hospital environment was for the reliable maintenance of robust IPC procedures. The concept of distinct Covid-19 care pathways was replaced in 2022. Instead, a screening tool was introduced to categorise patients into either a non-respiratory or a respiratory pathway. This change allowed for more targeted and adaptable management of Covid-19 and other respiratory cases. The 'screening tool' was introduced as part of the revised IPC triage guidance agreed by the four nations' chief medical and nursing officers.

308. The February 2022 toolkit, exhibited in **JPM3WGO02/86 – INQ000469140**, included design measures that would help control or mitigate risks, such as ventilation, barriers, and screens. Key mitigations included to:

   a) Ensure adequate ventilation systems were in place, i.e. mechanical/or natural national recommendations for minimum air changes were met as defined for the care area. This was to be carried out in conjunction with organisational estates teams/specialist advice from ventilation group and/or authorised

engineer on how best to achieve the recommended number of air changes as appropriate.

b) Identify areas (clinical and non-clinical) which were poorly ventilated or where existing ventilation systems were inadequate.

c) Maximise mechanical ventilation – advice could be sought from NHS Wales Shared Services – Specialist Estates Services, Ventilation Engineers.

d) Dilute air with natural ventilation by opening windows and doors where appropriate.

e) If considering screens/partitions in reception/waiting areas to ensure air flow was not affected and cleaning schedules were in place, ensuring they were not a fire hazard or risk of falls and trips. Consult with appropriate facilities and estate teams.

f) Assess whether room provision (negative, neutral and positive ventilation) was and would continue to be sufficient were there to be an increase in patients requiring isolation for respiratory infection. Work in a multidisciplinary team with hospital leadership, engineering and clinical staff to plan for creation of adequate isolation rooms/units.

g) Assess the function of the care area and ensure overcrowding was not an issue – particularly if patients with known or suspected respiratory infections were being cared for. Where there was adequate ventilation, this should be the priority area for infected patients to be cared for. Where a clinical space had very low air changes and it was not practical to increase dilution effectively then consider alternative technologies with the Estates/ventilation group.

309. This toolkit was supported by Welsh Health Technical Memorandums which were produced by the NHS Wales Shared Services Partnership Specialist Estates Services, whose website maintained the latest approved document. These documents were aimed at specifiers, designers, suppliers, installers, estates and facilities managers and operations within the NHS in Wales. Elements of the documents would also be relevant to managers concerned with the day-to-day management of healthcare facilities and senior healthcare management. The Welsh

Government was not required to review these and indeed would not have had the expertise to do so.

310. In March 2022 the Royal College of Nursing Wales called on the Welsh Government to invest in ventilation across the NHS estate. The Royal College of Nursing Wales provided a briefing calling on the Welsh Government to invest in the NHS estate, CO2 monitors and infection, prevention and control nurse consultants. These matters were discussed during the Quarterly Royal College of Nursing meeting with the Minister for Health and Social Services on 31 March 2022. The Minister gave reassurance that there was a lot of work already being undertaken by NHS Shared Services Partnership with regards to ventilation systems, guidance, ventilation safety groups and audits of ventilation. A copy of a note of that meeting is exhibited at **JPM3WGO02/86a - INQ000484924.** It was confirmed that based on current data there was no recommendation for a blanket installation of CO2 monitors at that time. A copy of the follow up letter to the Royal College of Nursing Wales is exhibited at **JPM3WGO02/86b - INQ000484925.**

311. The recommendations were considered by the Welsh Government Nosocomial Transmission Group and the NHS Shared Services Partnership-Specialist Estate Services. Updated guidance had recently been issued in December 2021 and was still considered appropriate, and there were no changes to the NHS estate as a result of the recommendations.

312. Throughout the pandemic there was considerable tension between those who advocated 'aerosol' transmission as the primary route of Covid-19 transmission and the UK IPC guidance which was based on evidence of 'droplet' guidance. In reality, this distinction was a somewhat false one as 'droplet' spread includes recognition of usually short-range aerosol transmission, which could spread further in enclosed unventilated spaces. The estates guidance in Wales provided advice to maximise ventilation but this was not always possible in older estates during the winter. Challenges to Welsh and UK Governments on the basis of aerosol spread were always taken seriously and new advice was regularly sought from the UK IPC cell producing the UK guidance to check the evidence that route of transmission was not changing during the pandemic as new variants arose.

IPC as a constraining factor in efforts to increase hospital capacity in Wales

313. The Covid-19 IPC guidance meant a different way of working for all sites and hospitals and reconfiguration of sites based on IPC guidance. Inevitably this impacted the efforts to increase capacity of hospitals both in terms of available beds and the number of patients who could be treated. Beds were spaced according to social distancing guidance, with Covid-19 and non-Covid-19 patients separated according to red and green areas as far as possible on the basis of symptoms and/or test results. The number of operations were reduced because of the time required to clean the area and change PPE between each patient, emergency departments had reduced capacity due to the need to separate respiratory from non-respiratory or Covid-19 from non-Covid-19 patients etc. Examples of how these issues manifested on the ground and how the Welsh Government was able to understand the feasibility of the guidance from the perspective of those 'on the ground' can be seen in the correspondence highlighted below:

   a) In July 2020 there was a chain of communication between Dr Andrew Goodall and Steve Moore, Chief Executive of Hywel Dda University Health Board, regarding the use of the Field Hospital at Carmarthen Leisure Centre and capacity across other sites exhibited at **JPM3WGO-02/87 – INQ000469027**. This email exchange illustrates the impact that IPC measures such as social distancing measures and ring-fencing wards for Covid-19 patients had on functional bed capacity. As set out in the email exchange, this resulted in a 192-bed reduction across the Health Board's acute sites including 113 at Glangwilli hospital.

   b) In an email to Dr Andrew Goodall on 12 October 2020 reporting on a meeting with CEOs and representatives from Local Health Boards, amongst others, regarding planned care arrangements, the point was raised that there was a lack of protected capacity and loss of cases per list because of IPC measures (as exhibited in **JPM3WGO-02/88 – INQ000469051**).

   c) On 26 October 2020 Andrew Sallows noted in a response on Covid-19 light sites that productivity and capacity had been significantly impacted by the requirement to use PPE and clean clinical areas to meet IPC requirements decline.

d) On 24 November 2020 the Community Health Councils in Wales report 'Feeling Forgotten' provided feedback on the views of the people of Wales covering a range of issues but also included delayed treatment and waiting times. A copy of this report is exhibited in **JPM3WGO02/90 - INQ000469292.** The Welsh Government noted that the number of procedures and operations had been affected by enhanced infection control, decontamination between operations and PPE which had increased the time needed for each surgery by 50%. Appointment time had increased to manage risk of infection and the new IPC procedures significantly constrained capacity.

e) In an update from Dr Andrew Goodall to the then Permanent Secretary, Shan Morgan, on the Health and Social Services Group and NHS response to Covid-19 capturing the period April 2021- September 2021 it was reported that IPC measures required for Covid-19 remained as a constant constraint leading to reduced capacity and workforce availability, despite additional funding (as exhibited in **JPM3WGO02/91 - INQ000083234**).

314. Despite the inevitable constraining factors that IPC guidance had on hospital capacity it is important to note that the IPC guidance was necessary to protect patients, staff, and visitors from Covid-19 and to prevent the spread of the virus in hospitals. While it may have constrained efforts to increase hospital capacity, it was a crucial factor in ensuring the safety of everyone in the hospital.

Guidance on aerosol generating procedures ('AGPs')

315. The Inquiry is interested in the development of guidance for aerosol generating procedures ("AGPs") and how that guidance changed during the relevant period. Guidance for Infection Prevention and Control measures during the Covid-19 pandemic, including in relation to AGPs, was developed jointly and issued via the UK Infection Prevention Control Cell, published by the Public Health Agencies in each country. The Welsh Government did not have a role in producing this expert clinical guidance and relied on the advice from the Public Health Agencies and IPC cell. AGPs are medical procedures that can result in the release of aerosols from the respiratory tract. These procedures carry a high risk of aerosol generation and an increased risk of transmission from patients with known or suspected respiratory infections. The guidance used in Wales did not differ from elsewhere in the UK.

316. All healthcare workers followed the national UK infection and prevention (IPC) guidance for Covid-19, which included instructions about different PPE ensembles that were appropriate for different clinical scenarios. The UK guidance in March 2020 was broadly consistent with the World Health Organization guidance. The only difference between the UK IPC guidance and the World Health Organization guidance was the recommendation to use aprons rather than gowns for droplet and contact precautions in the UK guidance and the use of FFP3 masks rather than N95 or FFP2 masks for AGPs. The apron recommendation in the UK is a long-standing recommendation for this transmission route and based on the requirement to be "Bare Below the Elbows" to enable effective hand hygiene, which is a key measure in reducing spread of this virus through contact. The use of FFP3 masks for AGPs was a specification in excess of that recommended by the World Health Organization. It was consistent with the advice of the Health and Safety Executive (HSE) that advised against the use of FFP2 or N95 masks, due to their lower efficacy.

317. The list of AGPs for healthcare settings in Wales is determined by a collaborative effort involving Public Health Wales, the National Infection Prevention and Control Manual (NIPCM), and consensus views from the UK Infection Prevention and Control (IPC) cell. These procedures were considered to be high-risk in terms of aerosol generation and increased risk of respiratory transmission from patients with known or suspected respiratory infections. Various additional procedures were purported to be AGPs during the pandemic, but advice was always taken from the UK IPC cell.

318. The medical procedures recognised as AGPs in Wales are as follows:

a) Awake bronchoscopy (including awake tracheal intubation)
b) Awake ear, nose, and throat (ENT) airway procedures involving respiratory suctioning
c) Awake upper gastro-intestinal endoscopy
d) Dental procedures using high-speed or high-frequency devices (e.g., ultrasonic scalers or high-speed drills)
e) Induction of sputum
f) Respiratory tract suctioning (including open suctioning beyond the oro-pharynx)
g) Surgery or post-mortem procedures likely to produce aerosols from the respiratory tract (upper or lower) or sinuses
h) Tracheostomy procedures (insertion or removal)

319. Following agreement by the UK's four chief medical and nursing officers, the AGP list was amended in June 2021 to include upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs beyond the oro-pharynx. I am not aware of any other additions to the AGP list during the pandemic.

320. Specific guidance issued by Public Health England covered the donning and doffing of PPE during AGPs for airborne precautions. PPE recommendations differ for AGPs compared to non-aerosol generating procedures.

Guidance on visiting restrictions

321. During the Covid-19 pandemic, hospital visiting guidance in Wales underwent several changes to balance the need for compassionate visits with robust infection prevention and control strategies.

322. I have set out below a table of the key guidance issued by the Welsh Government during the relevant period:

Table 15: Key guidance on visiting restrictions

Document Name	Exhibit Number	Document Date
Visitor guidance to in-patient health settings in times of Coronavirus (COVID-19)	**JPM3WGO02/92 – INQ000399385[43]**	25 March 2020
Update to visitor guidance to in-patient health settings in times of Coronavirus (COVID-19)	**JPM3WGO02/93 – INQ000299228**	20 April 2020
Hospital visiting during the coronavirus outbreak: guidance – visiting with a purpose	**JPM3WGO02/94 – INQ000299514**	20 July 2020
Hospital visiting during the coronavirus outbreak: guidance	**JPM3WGO02/95 - INQ000469208**	30 November 2020

[43] 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 [INQ000080902]

Document Name	Exhibit Number	Document Date
Hospital visiting during the coronavirus outbreak: Supplementary Statement November 2020	**JPM3WGO02/96 - INQ000469846**	30 November 2020
Review of hospital visiting	**JPM3WGO02/97 – INQ000469842**	1 April 2021
Hospital visiting during the coronavirus outbreak guidance	**JPM3WGO02/98 - INQ000082115**	18 June 2021
Hospital visiting during the pandemic: Supplementary statement June 2021	**JPM3WGO02/99 – INQ000082117**	18 June 2021
Hospital visiting during the pandemic: Supplementary statement December 2021	**JPM3WGO02/100 - INQ000469848**	14 December 2021
Hospital visiting during the coronavirus outbreak: guidance	**JPM3WGO02/101 – INQ000082810**	9 May 2022

323. The guidance listed in the table above covered:
    a) maternity units;
    b) paediatric inpatients;
    c) patients with learning or other disabilities;
    d) patients with limited Welsh or English language abilities or other communication difficulties;
    e) end-of-life patients.

324. In normal circumstances, the Welsh Government supports a person-centered flexible approach to visiting so patients and service users can see their families and loved

ones, however, during the Covid-19 pandemic we were not operating in normal circumstances, and we needed to ensure the safety of patients, service users, staff, and visitors themselves where possible.

325. I have provided a summary of the visiting restrictions that applied during the relevant period below. Further information on the visiting arrangements in place for end-of-life patients is set out later in this statement.

326. On the 25 March 2020 all visiting was suspended but there were some exceptions to this general advice and that visiting patients not infected with Covid-19 should be permitted for:
    a. One parent or guardian for paediatric inpatients and neonates.
    b. People receiving end of life care, if permission to visit secured was sought in advance from the ward sister/charge nurse and if granted, this should be one visitor at a time for a specified amount of time; and
    c. Women in labor should be permitted a birthing partner from their household.

327. Other exceptions were at the discretion of the Ward Sister/Charge Nurse or manager with advice from the Infection Prevention Control team. I have exhibited a copy of the letter dated 25 March 2020, as referred to earlier in the above table, setting out the restrictions at **JPM3WGO02/92 – INQ000399385.** It is noted in that letter that permission to visit any Covid-19 positive patients should only be given in extreme circumstances in line with pandemic guidance and with advice from the Infection Prevention Control Team. For those receiving end of life care, permission to visit should be secured, in advance from the ward sister/charge nurse and, if agreed, should be one visitor at a time for a specified amount of time and PPE should be provided, if appropriate.

328. On 20 April 2020, this guidance was updated by letter, as exhibited earlier in the above table at **JPM3WGO02/93 – INQ000299228**. The letter noted that on 8 April 2020, NHS England added an additional category of patients/service users to their visitor guidance: someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient/service user to be distressed.

329. This advice was formally included and updated on 20 July 2020, in the 'Hospital visiting during the Coronavirus outbreak: guidance', as exhibited in the table above at **JPM3WGO02/94 - INQ000299514**. A copy of the Written Statement made by the Minister for Health and Social Services regarding this guidance is exhibited at **JPM3WGO02/102 - INQ000469832,** and a copy of the letter sent from the Chief Nursing Officer for Wales dated 15 July 2020 to the NHS with details of the guidance is exhibited at **JPM3WGO02/103 - INQ000299515.** This updated guidance aimed to assist Local Health Boards and Trusts to strike a balance in terms of the visiting principles between allowing visiting with a purpose and the clear need to maintain robust infection prevention and control strategies. This guidance outlined that within non-Covid-19 areas and services:

a) One parent guardian, or carer at the bedside at a time for paediatric inpatients and neonates.

b) Patients who are in the last days of life – this can be up to two visitors at a time, for a specified amount of time, from the same household or part of an extended household. If not from the same household or not part of an extended household they should visit the bedside separately and maintain distance outside of the clinical area.

c) A birthing partner for women in labour, preferably from the same household or part of an extended household.

d) In general, one visitor at a time for a patient with mental health needs, learning disability or cognitive impairment, where lack of visiting would cause distress, or it is required as a reasonable adjustment to support access to health assessment or intervention. However, the number and frequency of visitors should be considered on an individual basis in light of the patient's/service user's needs, care plan and consultation with their support staff or carer.

e) Children and young people may visit a parent/guardian/carer or sibling in a healthcare setting and should be accompanied by one appropriate adult.

f) People with long term conditions which necessitate increased length of stay in a healthcare setting or people with specific care and well-being needs that the visitor/carer activity contributes to, for example, feeding, supporting communication needs and supporting rehabilitation. The health and well-being

of these patients may benefit from seeing appropriate visitors, as their length of stay is over many weeks.

330. In the July 2020 guidance any end-of-life Covid-19 patients were permitted to receive visitors during their last days of life provided permission was sought and granted in advance from the ward sister/charge nurse/nurse in charge. This was increased from one to two visitors, one at the bedside at a time, for a specified amount of time, preferably from the same household or part of an extended household. An exceptionality clause was added which gave Local Health Boards and Trusts discretion when operating the guidance to agree to visiting requests not outlined and where it benefited the well-being of the patient or visitor to outweigh the infection control risk and other practical difficulties.

331. The 20 July 2020 guidance also allowed visitors to accompany patients/service users to scheduled appointments in a healthcare setting. This may have been in the following situations, but were not exhaustive:

   a) Individuals with a mental health issues such as dementia, a learning disability or autism, where not being accompanied would cause the patient/service user to be distressed. Where possible, visits for such service users should be considered on an individual basis in light of the patient's/service user's needs care plan and in consultation with their support staff or carer.

   b) Individuals with cognitive impairment who may be unable to recall health advice provided.

   c) Where the treatment/procedure is likely to cause the patient distress and the visitor can provide support.

332. The guidance also permitted women attending hospital settings for the following specific pre-planned antenatal appointments to be accompanied by their partner or nominated other, preferably from the same household or part of an extended household:
   a. 12-week pregnancy dating scan
   b. early pregnancy clinic
   c. anomaly scan
   d. attendance at Fetal Medicine Department.

333. The guidance also anticipated that it may have been necessary for visitors to accompany patients/service users to unscheduled appointments, for example to emergency departments. If via ambulance this would have needed to be at the discretion of ambulance/emergency department staff and requests should have considered the individual patient's/service user's needs and the support which could have been provided by the visitor to help them understand their treatment and/or alleviate their distress.

334. An update to the guidance was issued on 30 November 2020, as exhibited in the table earlier at **JPM3WGO02/96 - INQ000469846**. A copy of the written statement outlining the update to the guidance made by Minister for Health and Social Services made on 30 November 2020 is exhibited at **JPM3WGO02/104 - INQ000300096**, and a copy of the letter sent from the Chief Nursing Officer for Wales dated 13 November 2020 to the NHS outlining the updates to the guidance is exhibited at **JPM3WGO02/105 - INQ000299694.** A supplementary statement, exhibited in the above table at **JPM3WGO02/96 - INQ000469846,** was included with the guidance which recognised that providers of health care to which the guidance applies may:

(i) in response to rising levels of Covid-19 transmission in their localities, including levels which result in a national lockdown, and/or evidence of nosocomial transmission within a particular setting; or

(ii) falling levels of transmission in their local area, depart from the Guidance.

335. Decisions to depart from the guidance were to be made by the Local Health Board, Trust or hospice's executive team with their infection prevention and control teams and in collaboration with Public Health Wales. Engaging with Public Health Wales to inform local decisions provides a collective reassurance that there is a consistent approach when taking decisions to impose visiting restrictions, which go beyond those set out in the guidance or indeed when relaxing the principles in the guidance.

336. The guidance issued on 30 November 2020 also provided a risk assessment methodology for Local Health Boards to determine the local maternity visiting for partners to accompany pregnant women and new mothers. As set out in the written statement, the risk assessed approach was required to be taken in collaboration

with the relevant health professionals, local infection prevention and control teams and Public Health Wales.

337. A review of guidance letter issued on 1 April 2021 as exhibited earlier at **JPM3WGO02/97 – INQ000469842** maintained the guidance and flexibility of the Supplementary Statement.

338. The revised hospital guidance, published on 18 June 2021 and brought into force on 5 July 2021, and exhibited earlier in the above table at **JPM3WGO02/98 - INQ000082115** reinforced the principle of local decision making based on local conditions, and retained the ability for providers to depart from the guidance in response to rising or falling levels of coronavirus transmission. The written statement made by the Minister for Health and Social Services in respect of the updated guidance is exhibited at **JPM3WGO02/106 - INQ000271665,** and a copy of the letter sent from the interim Chief Nursing Officer for Wales to the NHS in Wales dated 18 June 2021 outlining the changes as exhibited earlier in this statement at **JPM3WGO/101 - INQ000082810**.

339. The revised guidance also included a new annex which provided Local Health Boards and NHS Trusts with the option to use lateral flow testing, or point of care testing, to support hospital visiting. The use of testing for hospital visitors was to be determined at a local level implementing a 'hierarchy of controls', including protocols and procedures for social distancing, environmental cleaning and infection prevention and control, including PPE. It also made testing available for parents of children in hospital, pregnant women and their identified support partner and/or essential support assistants in maternity services. Subject to local determination and following a risk assessment, it also allowed up to two parents, guardians or carers at a time to visit a child in a paediatric inpatient ward or a baby in neonatal care.

340. On 12 August 2021 minor amendments were made to the guidance to ensure it aligned with the Care Home Visiting guidance and the Alert Level 0 guidance.

341. On 14 December 2021 the Supplementary Statement to the guidance was amended to acknowledge that Local Health Boards, Trusts and Hospices can restrict visiting and accompanying of patients to scheduled and unscheduled appointments for the purposes of infection prevention and control in response to risks posed by other (non-Covid-19) infectious diseases, and to recognise that the decision making process

with regard to visiting in a health care setting during Coronavirus may be multi-factorial. A copy of the updated Supplementary Statement was exhibited earlier at **JPM3WO02/100 – INQ000469848.**

342. On 9 May 2022, changes were made to the guidance concerning visiting restrictions in maternity services as exhibited earlier in **JPM3WGO02/101 - INQ000082810.** These changes outlined that a nominated partner supporting a woman during hospital visits and parents/primary care givers are partners in care, including neonatal settings, and as such should be categorised as essential visitors rather than visitors. The guidance was also changed to include a number of key principles which ensured there was a consistency of approach across Wales providing equity of experience.

343. I have exhibited a copy of the letter sent from the Chief Nursing Officer for Wales and the Deputy Chief Medical Officer for Wales dated 20 May 2022 outlining the de-escalation of Covid-19 measures at **JPM3WGO02/107 - INQ000353329**, which included expecting Local Health Boards and Trusts to step back from triaging of visitors and to be as flexible as possible in enabling hospital visiting while limiting overall footfall and in advising and supporting the use of face coverings.

344. The national hospital visiting guidance was removed on 11 November 2022.

345. Throughout the period the guidance aimed to strike a balance between allowing purposeful visits and maintaining infection control. The safety of patients, visitors, and staff remained the top priority.

346. The Inquiry has asked how the Welsh Government communicated the key points of visiting restrictions, and the exceptions where visiting was permitted, to the public. Whilst the guidance was intended for the NHS in Wales, all up to date guidance was published on the Welsh Government's website and was publicly available. Local Health Boards, NHS Trusts and hospices were ultimately responsible for developing local communication strategies to inform the public of the restrictions in place at the time. This could include providing information on their websites, social media and in appointment letters.

Issues concerning the timing and frequency of changes to IPC guidance for healthcare settings

347. As noted above Guidance for Infection Prevention and Control measures during the Covid-19 pandemic was developed and issued via the UK Infection Prevention Control Cell. The updated Covid-19 Infection prevention and control guidance was produced and released on 2 April 2020, as exhibited **JPM3WGO02/108 - INQ000383819**. It was agreed and adopted by all four nations. The guidance was evidence based and approved by NERVTAG and the Health and Safety Executive. It provided general information on how to prevent the spread of Covid-19 in healthcare settings, including hospitals, care homes, and primary care settings. It covered topics such as hand hygiene, PPE, cleaning and disinfection, and patient placement. It was regularly reviewed and updated as evidence grew on the nature of Covid-19. It was noted in an advice letter of 8 April 2020 from Public Health Wales that Local Health Boards, Trusts and other health and social care providers in Wales should be applying the updated IPC guidance including implementation of the recommendations of when to use PPE for patient encounters, as exhibited in **JPM3WGO02/109 – INQ000468927.**

348. On 9 April 2020 a Supplementary Advice Note was released following requests to the Welsh Government for practical advice examples for social care providers in relation to the updated IPC guidance. The note explained the changes to the IPC guidance and identified the need to continuously check the live web links as the guidance was constantly evolving, as exhibited in **JPM3WGO02/110 – INQ000468930.** Throughout the entirety of the relevant period, there were 670 changes made to IPC guidance in total.

349. Alongside the UK Covid-19 IPC guidance there was Wales specific NHS Management guidance and a National Infection & Control Manual for Wales updated and published by Public Health Wales and referred to in the Principles Framework to assist the NHS in Wales to return to urgent and planned services, published in June 2020, as exhibited in **JPM3WGO02/111 - INQ000299363.**

350. There were some concerns about the timing and frequency of IPC guidance in Wales during the pandemic. In June 2020, the Welsh Government was criticised for the delay in publishing guidance on the use of PPE for healthcare workers. There were also concerns about the lack of clarity and consistency in the guidance provided to care homes and other healthcare settings. Another concern was the frequent changes to IPC guidance, which made it difficult for healthcare workers and facilities to keep up with the latest recommendations. However, the Welsh Government and

Public Health Wales updated their respective guidance as it was needed and took steps to improve communication, ensuring clarity of the messaging and providing support for healthcare workers including clear and consistent recommendations on how to prevent the spread of Covid-19 and the provision of IPC training and mental health support.

351. The UK Covid-19 IPC Guidance Cell met regularly throughout the pandemic with representation from IPC specialist across all four nations, which for Wales was via Public Health Wales. It considered all latest evidence, World Health Organisation briefings and International IPC guidance and used this inform the updates the UK IPC guidance.

352. In December 2021 both the four Chief Nursing Officers of the United Kingdom and the four Chief Medical Officers of the United Kingdom raised concerns about whether changes to the IPC guidance were being made quickly, and went far enough, to respond to the risks posed by the Omicron variant. Although the Omicron variant was considered to be associated with increased transmissibility and immune escape, no changes were made to IPC guidance were recommended by World Health Organisation, Centre for Disease Control and Prevention, UK Health Security Agency, or the Medicines and Healthcare products Regulatory Agency. I exhibit copies of the correspondence sent by the Chief Nursing Officer for Wales to the UK IPC Cell at **JPM3WGO01/111a – INQ000227346**, and correspondence sent from Public Health England citing concerns of the Chief Medical officers of the UK at **JPM3WGO02/112 - INQ000252535.** As noted in the response of Dr Eleri Davies (Chair of the UK IP&C Cell), it was considered that no changes to the guidance were required because there was no evidence that the mode of the transmission of the virus had changed but that the position would continue to be evaluated.

Issues concerning Local Health Boards having sufficient time after the receipt of revised guidance to implement new IPC measures within stipulated time frames

353. Wales moved from a Contain to Delay phase on 13 March 2020 upon which the Welsh Government provided guidance on Infection Prevention Control. This guidance was developed by Public Health Wales and the NHS Wales Shared Services Partnership and was consistent with the advice disseminated by Public Health England, Public Health Scotland and World Health Organisation.

354. The UK IPC Cell issued guidance on infection prevention and control measures for healthcare settings during the pandemic. The guidance was based on the best available evidence at the time, and given the rapidly evolving situation, was continually reviewed and renewed as new information became available. It was the responsibility of the Local Health Boards to ensure that they were implementing the guidance appropriately.

355. Feedback was sought and provided by not only Local Health Boards but also Local Resilience Forums and Local Authorities on their capacity to adapt to the change in guidance. Feedback was received by the Welsh Government (and sought) through Chief Executives, Workforce Directors as well as other channels.

356. While it is possible that some Local Health Boards may have faced challenges in implementing new IPC measures within stipulated time frames, the Welsh Government worked closely with Local Health Boards to ensure that they had the support and resources they needed to implement new IPC measures in a timely manner. This included the work of the Nosocomial Transmission Group (NTG), described further below and in the Chief Nursing Officers' Module 3 witness statement (reference M3-CNO-01), the Delivery Unit of the Covid-19 Rapid Sharing of Early Learning (CoRSEL) system, which aimed to learn and share lessons in close to real time during the first wave of the pandemic, and the 'NHS Wales national framework – Management of patient safety incidents following nosocomial transmission of COVID-19', which health boards used to learn from incidents of harm from nosocomial transmission.

Issues concerning any other matters relating to issues in communicating or implementing changes to IPC guidance for healthcare settings

357. The Welsh Government was made aware on several occasions of differences between IPC guidance issued by different bodies, for example Public Health England/Wales and the Royal College of Obstetricians and Gynaecologists. In particular, there were discussions around adopting a four nations approach and consideration of the implementation of Public Health England guidance in Wales. Consideration was given to the implementation of guidance adopted by Public Health England and the NHS in England and if and how, this would be adopted in Wales. Throughout the pandemic questions were raised about the possible impact of

changes to restrictions in different nations and the impact this could have on the implementation of IPC whilst maintaining a four nations approach.

358. For example, on 25 March 2020 it was brought to the attention of Welsh Government that there appeared to be discrepancies between Public Health Wales advice and for example Royal College of Obstetricians and Gynaecologists advice. Public Health Wales were following Public Health England guidance, and the Royal College of Obstetricians and Gynaecologists were following their own which was not approved via UK IPC channels, as noted in exhibit **JPM3WGO02/113 – INQ000468920**.

359. On 5 June 2020, the Chief Nursing Officer for England confirmed to Chief Nursing Officer for Wales that the English policy in respect of wearing face masks in hospital settings for hospital visitors and staff in non-clinical areas would be announced that day following sign off by SAGE. It was noted that the Secretary of State would like a four nations approach and that the Welsh Government would need to agree a position on this, as noted in **JPM3WGO02/114 – INQ000468997**. Again, in July 2021, it was noted that there were discussions in the healthcare system in respect of the impact of potential changes to restrictions in England and their impact on IPC guidance/requirements in health and social care as noted in **JPM3WGO02/115 – INQ000469123.**

Impact of efforts to reduce the spread of Covid-19 in healthcare settings upon the experiences of NHS staff in Wales

360. The impact of the IPC measures on the availability of staff in Wales during the pandemic is a complex issue. While the measures were necessary to prevent the spread of Covid-19, they also had unintended consequences, such as staff shortages due to illness or self-isolation. The measures also required additional training and resources, which put a strain on the healthcare system.

361. To mitigate the impact of IPC measures on staff availability, the Welsh Government implemented a range of measures, including recruiting additional staff, providing additional training, and increasing the availability of PPE. The Welsh Government also introduced a range of financial and other support measures to help staff cope with the additional demands placed on them during the pandemic. This included a one-off bonus payment of £735 in March 2021. Other measures included: funding for the implementation of Consultant Connect for the provision for specialist clinical

advice for GPs and paramedics; expansion of the Health for Health Professionals Service (providing mental health support for NHS staff); funding for additional staff; funding for additional space and capacity; key worker support measures such as childcare/school attendance; regular testing; earlier vaccination; and revised HR policies within NHS organisations such as carrying over unused leave.

362. Local Health Boards could not have anticipated the number of staff absences which were caused by the requirements to self-isolate, staff testing positive for Covid-19 and staff being absent due to fatigue. Local Health Boards were looking at different options to help with this including freeing up nursing and surgical staff where they would otherwise have been involved in elective treatments.

363. In a summary of the Health and Social Services Group's ongoing response to the pandemic for the period April to September 2021, previously exhibited as **JPM3WGO02/91 - INQ000083234,** it was noted that the overall workforce was at record levels with over 103,000 staff directly employed by the NHS in Wales organisations. This was 4000 more than at the same time in 2019. It was acknowledged that IPC measures remain a constraint on capacity, especially for the recovery of routine dental care, but minimising the nosocomial transmission of Covid-19 within health and care settings was a national priority throughout the pandemic. In the same summary the impact of staff absence in neonatal services was addressed. A significant number of staff had been absent either through illness, stress, needing to isolate or caring for family members.

364. Similar to the effect of IPC measures on staff absence, there were other unintended consequences, such as increased workload, stress, and anxiety among healthcare workers. The healthcare workforce was amongst those most vulnerable throughout the entire pandemic as they continued to work in settings where Covid-19 was often most prevalent. They therefore were a part of the most impacted by efforts to reduce the spread of Covid-19. Continuing their work in the manner in which they had done previously pre pandemic had significantly changed, with the implementation of IPC measures for example and the enhanced use of PPE.

365. The measures required additional training and resources, which put a strain on the healthcare system. The need to wear PPE for extended periods of time was also uncomfortable and made communication with patients and colleagues more difficult.

The risk of contracting Covid-19 and passing it on to family members also added to the stress and anxiety experienced by healthcare workers.

366. An implementation toolkit was published by NHS England and shared with Local Health Boards in Wales for the purpose of addressing behavioural compliance with IPC measures as exhibited in **JPM3WGO02/116 – INQ000469099**. Feedback was taken from front line staff when drafting the toolkit. The toolkit was shared via the Local Health Board IPC leads (in this instance via Office of the Chief Nursing Officer – Gareth Howells). Wellbeing and morale were a feature in the toolkit, and it provided ideas that could be implemented such as message support boards, mindfulness moments, speak up champions, safety words and an anonymous escalation process.

367. The Royal College of Nursing Wales reported in May 2020 on the results of a survey of nurses which found that a considerable percentage of nurses raised concerns about PPE and felt pressured to care for a patient without any PPE, as noted in **JPM3WGO02/117 – INQ000427472**. Dr Goodall, at paragraphs 361-377 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01) has explained the steps taken by the Welsh Government to manage and increase the availability of PPE supplies. By July 2020 a Senedd report by the Health, Social Care and Sport Committee found that the situation had improved.

368. The Welsh Government sought to learn lessons throughout the pandemic and views were sought from Local Health Boards following the first wave of the pandemic. I exhibited a lessons learned document earlier in this statement at **JPM3WGO02/65 – INQ000227419**. The feedback from some Local Health Boards noted morale problems and tiredness due to the sheer amount of change staff were having to cope with. However other feedback was that staff were mostly motivated and resilient.

369. The Welsh Government coordinated its approach to IPC measures and practices at policy level through the Nosocomial Transmission Group (NTG) which was established in May 2020 as part of the Planning and Resilience Group arrangements. The NTG was chaired jointly by the Chief Nursing Officer for Wales and the Deputy Chief Medical Officer for Wales and comprised policy colleagues with a range of NHS organisation representatives. It provided a mechanism for information and data sharing and mutual updates for learning and new policies and evidence were presented and discussed. The NTG supported the development of and issued an extensive range of guidance, including on implementing IPC guidelines, Covid-19

testing, cleaning standards, bed spacing, ventilation and environmental controls. The work of the NTG and its products are described in greater detail in the Chief Nursing Officers' witness statement (reference M3-CNO-01)

370. Despite these challenges, many healthcare workers in Wales demonstrated remarkable resilience and dedication to their work. The Welsh Government and healthcare organisations also implemented a range of measures to support staff morale during the pandemic, including providing additional mental health support, offering flexible working arrangements, and recognising the efforts of healthcare workers through public campaigns and other initiatives.

371. Efforts to reduce the spread of Covid-19 in healthcare settings had a significant impact on staff members of different ages, sexes, ethnic backgrounds, and roles. The pandemic highlighted existing inequalities within the healthcare system and brought attention to the need for greater equity and inclusion in healthcare. The application of IPC measures across Local Health Boards and Trusts in Wales would have been based upon organisational and individual risk assessments at the time, and steps taken to address any identified impact on different groups would have been taken at a local level.

372. One of the key impacts of efforts to reduce the spread of Covid-19 was on staff members who were at higher risk of infection due to their age or underlying health conditions. Older staff members and those with underlying health conditions were at greater risk of severe illness from Covid-19, and were therefore more likely to require additional protection and support in the workplace.

373. Efforts to reduce the spread of Covid-19 also had an impact on staff members of different ethnic backgrounds as they were at higher risk of infection and severe illness from Covid-19. This was due to a range of factors, including higher rates of underlying health conditions and greater exposure to the virus due to their roles in the healthcare system.

374. In addition, efforts to reduce the spread of Covid-19 had an impact on staff members in different roles within the healthcare system. Frontline staff members, such as nurses and doctors, were at greater risk of exposure to the virus due to their roles in caring for patients with Covid-19. Support staff members, such as cleaners and

porters, were also at risk of exposure due to their roles in maintaining the cleanliness and safety of healthcare settings.

375. The Welsh Government has taken several steps to address the inequalities in impact of Covid-19 on staff members of different ages, sexes, ethnic backgrounds, and roles within the healthcare system. These steps were taken to ensure that all staff members had access to the resources and support they needed to deliver care to patients during the pandemic.

376. From April 2020 the Welsh Government was alive to the possibility that certain ethnic groups were disproportionately impacted by Covid-19. In looking at workforce issues and risks, the Welsh Government sought data from the Health and Safety Executive and SAIL and sought advice from the Race Council Cymru.

377. Whilst it was the Welsh Government's position that all staff should have PPE available to them, it worked hard to ensure that all those at higher risk of infection or severe illness from COVID-19 had support and protection. This included providing additional PPE and ensuring that staff members with underlying health conditions such as diabetes were able to work in lower-risk roles or work from home where possible. The Chief Nursing Officer for Wales discussed research coming from within Public Health England that some from Black and Minority Ethic Backgrounds were more at risk with Directors of Nursing. The Chief Nursing Officer for Wales asked Directors of Nursing to consider individual staff cases when looking at whether to deploy to Covid-19 areas, not just make decisions for groups of people. The development of the All Wales Covid-19 Risk Assessment Tool in May 2020 (discussed later in this statement) was key to supporting employers and employees to identify those at high risk and put in place protections and mitigations including working from home if necessary.

378. The Welsh Government also established the First Minister's Black, Asian and Minority Ethnic Covid-19 Advisory Group ("the Advisory Group") to provide advice and guidance on how to address the impact of the pandemic on staff members from diverse backgrounds, together with two subgroups: the Socioeconomic subgroup, and the Workforce Risk Assessment subgroup. The Advisory Group and its subgroups provided recommendations on how to reduce the risk of infection and improve the health and wellbeing of staff members from diverse backgrounds.

379. Some of the key recommendations arising out of the work of the Advisory Group and its subgroups included ensuring that staff members from Black Asian and Minority Ethnic backgrounds were able to access appropriate PPE and that the PPE was tailored to their specific needs and conducting regular risk assessments to identify and address any issues that may be impacting staff members from Black Asian and Minority Ethnic backgrounds. The Welsh Government took these recommendations into account in its response to the pandemic and has worked to ensure that the healthcare system is more equitable and inclusive. I have provided further information on the Advisory Group and its subgroups, including the reports of the subgroups and the Welsh Government response, later in this statement.

380. In addition, the Welsh Government provided additional training and support for staff members in different roles within the healthcare system. This included providing training on infection prevention and control, mental health and wellbeing support, and additional resources for staff members as described earlier this statement.

Palliative care

381. The Inquiry has asked me for information about palliative care. In order to address these questions, I have received support from Professor Chris Jones, Deputy Chief Medical Officer for Wales.

Issues regarding instances of Covid-19 patients failing to receive palliative care at the end of life and actions taken in response

382. The Welsh Government required that palliative and end of life care in all hospital and community settings must continue throughout the relevant period. This is illustrated in the guidance issued by the Essential Services Group within the Welsh Government "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 4 May 2020 exhibited earlier in the statement at **JPM3WGO02/08 - INQ000182443** and updated on 12 June 2020, also exhibited earlier in the statement at **JPM3WGO02/16 - INQ000182461**, which were required to be read respectively with Quarters 1 and 2 NHS Wales Operating Framework as exhibited earlier in the statement at paragraph.

383. I am not aware of any specific reports which were brought to the attention of the Minister for Health and Social Services regarding any failures to meet this

requirement or of any particular instances of Covid-19 patients failing to receive palliative care at the end of their life.

Issues regarding lack of resources in hospital palliative care teams and actions taken in response

384. The Welsh Government was aware of issues with respect to (i) the supply of drugs and drug delivery equipment for end-of-life care and (ii) hospice funding and (iii) local availability of PPE. I have previously set out the issues with respect to the supply of drugs and drug delivery equipment for services including end-of-life care earlier in the statement. I outline the other issues below.

Hospice funding

385. The Welsh Government recognises that hospices, as well as NHS teams, have an important role in sustaining expert inpatient and community care during the pandemic. Hospice funding was a regular theme during the relevant period, and I exhibit two ministerial advice notes seeking agreement to increase emergency funding available at **JPM3WGO02/125 - INQ000235983** and **JPM3WGO02/126 - INQ000145051**.

Local availability of PPE

386. The Welsh Government received correspondence about difficulties in obtaining PPE in hospitals. For example, on 1 April 2020, the Welsh Government was made aware of a nurse rotation system at Prince Charles Hospital where staff from regular wards were required to work on palliative care Covid-19 wards. Although staff had access to standard surgical masks, short gloves and plastic general use aprons, it was reported to Welsh Government that these weren't fit for purpose. Concerns were also raised by charitable hospices regarding a lack of supply and access to PPE. I exhibit a written statement made by the Minister for Health and Social Services on PPE dated 25 March 2020 at **JPM3WGO02/127 – INQ000299063** and a written question and answer provided by the Minister for Health and Social Services on 4 April 2020 which outlines the steps taken to ensure that suitable PPE was provided to hospitals and hospices by Local Health Boards at **JPM3WGO02/128 – INQ000469844.**

Role and function of the NHS Wales End of Life Care Board and reasons for its establishment

387. The End of Life Care Implementation Board is an NHS board which was established in 2014 for the purposes of providing national leadership and support, and acted as a forum to drive forward change and support Local Health Boards' efforts to deliver the Welsh Government's vision for improving end of life care in Wales. I exhibit a copy of its terms of reference at **JPM3WGO02/129 – INQ000469811**. The End of Life Care Implementation Board included representation of all those involved in the delivery of end of life care, including Welsh Government representatives and was responsible for overseeing the delivery of the end-of-life care delivery plan published by the Welsh Government in 2015 and refreshed in 2017.

388. The End of Life Care Implementation Board operated until 2022 when it was succeeded by the National Programme Board for Palliative and End of Life Care.

Role of the Welsh Government or NHS Wales End of Life Care Board in formulating or co-ordinating national Covid-19 palliative care guidelines

389. The Welsh Government worked with the National Clinical Lead for Palliative and End of Life Care and the NHS Collaborative to produce "Essential Services Guide: Palliative Care Information and Resources during Covid-19". The guide provided information, advice and links to resources to support health, social care and third sector organisations to respond to the Covid-19 pandemic in relation to palliative and end of life care. The focus was on guidance and advance which will help achieve a dignified and compassionate care at the end of life for adult patients who would not benefit from life support, or where this has not been successful and where their condition had deteriorated as a result of Covid-19. I exhibit a copy of the Essential Service Guide: Palliative Care Information and Resources during Covid-19 dated 12 May 2020 at **JPM3WGO02/130 – INQ000183729**[44] together with a letter from the Deputy Chief Medical Officer for Wales dated 12 May 2020 bringing the guide to the attention of care homes, general practices, voluntary hospices, specialist palliative care teams, Local Health Boards and NHS Trusts, Royal College of General Practitioners and Royal College of Nursing at **JPM3WGO02/131 - INQ000299293.**

[44] 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 [INQ000299296]

An updated version of the guide dated 2 September 2020 is exhibited at **JPM3WGO02/132 – INQ000469311.**

390. Further information on the actions taken by the Welsh Government, the End of Life Care Board and clinical teams across Wales in relation to palliative and end of life care during the Covid-19 pandemic is exhibited in **JPM3WGO02/133 – INQ000361494**. This includes the publication of the Community Covid-19 Framework (outlined in more detail later in this statement and exhibited at **JPM3WGO02/134 – INQ000226967** and **JPM3WGO02/135 – INQ000227398**) which includes guidance on symptom control medication for palliative and end of life care within the community and the All Wales Covid-19 Secondary Care Management (exhibited at **JPM3WGO02/136 – INQ000373221)** which includes symptom control guidance for patients in hospitals to complement the existing guidance on care in the last days of life (known as the Care Decisions Tool).

391. Other clinical guidance for palliative and end of life care was given by professional clinical bodies and links were provided in the Essential Services Guide: Palliative Care Information and Resources during Covid-19.

Visiting rules for patients at the end of life

392. In general terms, the rules permitted visitors to people receiving end of life care, with permission to visit secured in advance from the ward sister/charge nurse.

393. Guidance on visiting in healthcare settings was first issued as a letter from the Chief Nursing Officer for Wales to NHS Wales Nurse Directors and NHS Wales Chief Executives on 25 March 2020 exhibited earlier in this statement at **JPM3WGO02/92 - INQ000399385**. It provided advice on visiting people both not infected and infected with COVID-19 and receiving end of life care. Permission to visit was to be secured in advance from the ward sister/charge nurse and if agreed, should be one visitor at a time for a specified amount of time. PPE was to be provided if appropriate.

394. This advice was emphasised in a further letter sent from the Chief Nursing Officer for Wales on 20 April 2020 to NHS Wales Nursing Directors and NHS Wales Chief Executives exhibited earlier in this statement at **JPM3WGO02/93 - INQ000299228** which highlighted the need to support end of life COVID-19 patients.

395. Guidance which commenced on 20 July 2020 exhibited earlier at **JPM3WGO03/94 - INQ000299514** again stated permission to visit was to be secured in advance from the ward sister/charge nurse. It allowed for up to two visitors at a time for a specified amount of time from the same household, or part of an extended household. If not from same household or not part of an extended household, they should visit the bedside separately and maintain distance outside of the clinical area. An exceptionality clause was added which gave Local Health Boards and Trusts discretion when operating the guidance to agree to visiting requests not outlined and where it benefited the well-being of the patient or visitor to outweigh the infection control risk and other practical difficulties. This guidance (together with all other visiting guidance referred to in this section) was intended for the NHS in Wales, not the public.

396. Guidance which commenced on 30 November 2020 exhibited earlier at **JPM3WGO03/137 - INQ000081643** maintained the above visiting restrictions for people at the end of life but added an annex of consideration for visiting in non-COVID-19 hospice settings. This allowed, with advance agreement from the hospice manager, for up to two visitors at a time for a specified amount of time from the same household, or part of an extended household. If not from the same household or not part of an extended household, they should visit the bedside separately and maintain distance outside of the clinical area. As set out earlier in this statement, a supplementary statement was also included with the guidance which afforded health providers flexibility to depart from the guidance in response to rising levels of Covid-19 transmission in their localities and falling levels of transmission in their local area. Decisions to depart from the guidance were to be made by the Local Health Board, Trust or hospice's executive team with their infection prevention and control teams and in collaboration with Public Health Wales. Engaging with Public Health Wales to inform local decisions provided a collective reassurance that there is a consistent approach when taking decisions to impose visiting restrictions, which go beyond those set out in the guidance or indeed when relaxing the principles in the guidance.

397. A review of guidance letter issued on 1 April 2021 exhibited earlier at **JPM3WGO02/97 - INQ000469842** maintained the guidance and flexibility of the Supplementary Statement.

398. An annex for visitor testing principles was added to guidance was published on 18 June 2021 and came into force on 5 July 2021 exhibited earlier in the statement at **JPM3WGO02/98 - INQ000082115** which made it clear the use of testing for hospital visitors was to be determined at a local level and empahsised the use of a 'hierarchy of controls'. This included protocols and procedures for social distancing, environmental cleaning and infection prevention and control, including PPE, remain the principal ways of preventing the entry and spread of Covid-19 within health care settings.

399. On 12 August 2021 minor amendments were made to the guidance to ensure it aligned with the Care Home Visiting guidance and the Alert Level 0 guidance.

400. On 14 December 2021 the Supplementary Statement to the guidance was amended to acknowledge that Local Health Boards, Trusts and Hospices can restrict visiting and accompanying of patients to scheduled and unscheduled appointments for the purposes of infection prevention and control in response to risks posed by other (non-Covid) infectious diseases, and to recognise that the decision making process with regard to visiting in a health care setting during Coronavirus may be multi-factorial.

401. Throughout the pandemic, the Welsh Government recognised that restrictions on visiting can impact adversely both on patients and their loved ones. The health, safety and wellbeing of patients, communities and health care provider staff remained an absolute priority. Virtual visiting in healthcare settings was encouraged and supported where possible.

402. On 11 November 2022, all restrictions on visiting patients in hospital, including those on end-of-life care, ceased.

403. The Welsh Government sought to learn lessons from the Covid-19 pandemic including in relation to end of life care. I exhibit an email dated 15 February 2021 following a request from the Minister for Health and Social Services officials in the Health and Social Services Group reflecting on the impact of Covid-19 on end of life and palliative care at **JPM3WGO02/139 – INQ000469089.** This noted that basic palliative care measures worked well in Covid-19, including drugs for symptom control but recognised that keeping visitors away made it harder to provide good care for patients and much harder to support families, particularly when it came to communicating with them and providing support around time of death. This work,

which informed the Welsh Government's recovery planning, noted the need to use this to get better at identifying who needs palliative and end of life care, when, and where, identifying what their priorities are, and at identifying those experiencing bereavement to build robust systems for responding to these needs.

Involvement of the Welsh Government or NHS bodies in formulating guidance relating to communicating with patients and their families regarding treatment decisions, advanced care planning, DNACPRs and end of life care

404. Details of the advance/future care planning and treatment escalation plans were set out in the Essential Services Guide: Palliative Care Information and Resources during Covid-19 dated 12 May 2020 exhibited earlier in this statement at **JPM3WGO02/130 – INQ000183729** and dated 2 September 2020 as exhibited earlier at **JPM3WGO02/132 – INQ000469311.** This included guidance to support decision making during Covid-19 along with additional supporting guidance produced by the Advance Future Care Planning Strategic Group working with the national clinical lead for End of Life Care, and an All Wales Treatment Escalation Plan which provided guidance and structured handover of decisions and conversations that have been held. The guide also refers to guidance produced by other bodies such as the General Medical Council and Nursing and Midwifery Council and Health Inspectorate Wales/Care Inspectorate Wales. Welsh Government officials were part of the Advance Future Care Planning Strategic Group and therefore had an indirect involvement in the formulation of these plans and guidance.

405. The All Wales clinical policy entitled 'Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales' in place between 2020 and 2022 and exhibited at **JPM3WGO02/139a - INQ000283301**[45] also contained 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, additional resources for patients and their loved ones considering DNACPR, the requirements and responsibilities of the senior responsible clinician with oversight, and organ donation. Welsh Government officials were part of the Advance Future Care Planning Strategic Group and therefore had an indirect involvement in the formulation of this clinical policy.

[45] 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 [INQ000227414]

Shielding

406. The Inquiry has asked me for information about shielding. In order to address these questions, I have received support from Sioned Rees (Interim Director Public Health Protection).

Issues that came to the attention of the Welsh Government in respect of shielding patients

407. At the time of the initial introduction of the Shielding Patient List in March 2020, numerous emails and telephone calls were received from members of the public seeking clarification as to whether a particular condition would be caught under the category of clinically extremely vulnerable and require them or a family member to shield. Examples of matters brought to the Welsh Government's attention in March and April 2020 included:

   a. Queries asking whether multiple sclerosis patients should be shielding. At the time, multiple sclerosis patients were included in the "at risk" group and not included in the list of conditions which made up the Shielding Patient List and therefore did not receive the shielding letter.

   b. A request for clarification regarding the inclusion of people with asthma. On 3 April 2020, a public health link letter from the Senior Medical Officer was issued which included the definition of 'severe asthma; to which shielding advice applied. The letter is exhibited in **JPM3WGO02/140 - INQ000048588**.

   c. A request for clarification for palliative care consultants and Hospice UK for those receiving palliative care as to whether those patients should shield or not. Some of those patients were included on the Shielding Patient List whilst others were not. This was due to balancing the risk of contracting the virus against the likelihood of their possible death in the next six months and the importance of maintaining relationships with family towards the end of their life.

   d. A query raised by an arthritis support group regarding potentially conflicting advice for those with musculoskeletal conditions, suggesting that the Welsh Government criteria for high risk did not match the criteria developed by the British Society of Rheumatology. There was concern that individuals may receive conflicting advice regarding shielding from different sections of the

NHS. For example, the possibility of primary care using Welsh Government criteria whilst rheumatology departments using British Society of Rheumatology criteria.

e. Concerns from people with well-controlled HIV who had received a UK Government text erroneously advising them to shield, contrary to shielding advice. This was identified to be a text issued in error and was being investigated by the UK Government and the Chief Medical Officer for England's office. It was noted to have caused huge concern across the UK-wide HIV community, and that it would undoubtedly have affected some of those in Wales as well.

408. Those identified as "at risk" initially included those over 70 years of age, those who have asthma and those who were diagnosed with multiple sclerosis. This group was identified as needing to take extra care (e.g. practice rigorous social distancing) but were not considered to be clinically extremely vulnerable. The categories of persons who were considered to be clinically extremely vulnerable and therefore on the Shielding Patient List was determined by the clinical advice provided by the UK Chief Medical Officers and was kept under continual review.

409. In terms of other issues, there were also logistical issues relating to the sending and receiving of shielding letters:

a. On 10 April 2020, the Welsh Government became aware that up to 13,000 letters (out of approximately 91,000 letters issued) to shielding people were sent to the wrong address by NHS Shared Services. This came to light as part of the data validation exercise, where it was identified that a significant number of patient letters had been sent to their old address. The Welsh Government was informed that letters were subsequently issued to the correct addresses over the course of Easter weekend (i.e. 11 and 12 April 2020).

b. Concerns were raised about delay in receiving a shielding letter either because the individual had been advised by their GP, they would receive such a letter, or because they believed they fell within the category of vulnerable and therefore should have received such a letter. Media enquiries were received quoting the British Medical Association as saying there were delays with the

letters going out causing confusion amongst the general public as the Welsh Government website directed them to their GP and GPs directed them back to the Welsh Government. Exhibited in **JPM3WGO02/141 – INQ000468974**, on 9 April 2020 the Community Health Council raised a concern some people were still unsure about who sent out shielding letters, the Welsh Government or GPs or someone else. It was noted that guidance and public messaging had provided clarity nationally, but concerns remained that some GPs were still (erroneously) advising people that it was not their role to provide a letter to patients at high risk, even where they agreed it was needed. To respond to the concern and provide clarity the relevant Local Health Boards re-issued further guidance to GPs.

c. There were issues with some patients who had the wrong code attached to their patient record. A dedicated mailbox for the Shielding Patient List was set up to address this concern and the issues were resolved with Digital Health and Care Wales.

d. Some patient records included out of date addresses. To rectify these clear instructions were sent to patients to correct this with their GP as well as the information to share with their GP.

410. The Welsh Government and the Chief Medical Officer were responsible for the content of letters to those on the Shielding Patient List and oversaw their issue, including commissioning the printing. Whilst the printing and distribution was initially carried out by NHS Wales Shared Services Partnership this was later undertaken using a private contractor. The Shielding Patient List was collated and maintained by NHS Wales Informatics Service (latterly known as Digital Health and Care Wales) throughout the relevant period. This list was utilised whenever there was a requirement to write to those on the Shielding Patient List, including informing them of changes to guidance and advice. If patients were added to the Shielding Patient List by their GP, the corresponding advice at the time, in the form of a letter, was issued to them by their GP.

411. On 16 April 2020, the Minister for Health and Social Services received a collective letter from several charities supporting people with long term health conditions. The letter, exhibited at **JPM3WGO02/142 - INQ000468979** raised a number of issues

reported to the charities regarding the shielding advice and communication. These included:

a. People not receiving a shielding letter who the charities would consider at risk.

b. People not receiving a letter from the Chief Medical Officer for Wales but receiving a letter from primary/secondary care staff telling them to shield.

c. Secondary care services generating their own lists and sending out letters using their own criteria, differing from location to location and specialty to specialty.

d. The criteria for identifying at risk people differing from that used by professional bodies, for example people with multiple sclerosis.

e. People receiving a shielding letter who have long term conditions but who are not currently on medication (and have not been in the last 12 months) nor have any of the identified risk factors.

412. The letter recommended that the Welsh Government consider the following actions:

a. Utilise a similar model as that used in Scotland, whereby Local Health Boards have been asked to set up local Shielding Letter Co-ordinating teams involving both primary and secondary care who will validate and add individuals to the list (using consistent criteria), which will then be sent back to central government to co-ordinate communication to people needing to shield using one consistent letter.

b. Ensure that all brand names of drugs are included in the list.

c. Provide charities and other organisations information clarifying the process by which individuals can apply for shielding letters who believe they should have received the letter so we can support our service users.

d. Seek an additional approach by which people can request a shielding letter (for example a central online registration form), given that we understand that people are finding it difficult to get through to their surgeries.

e. Ask health professional bodies to validate the criteria used by the Welsh Government to identify high risk patients.

f. Ensure that when the shielding lists are updated, the updated list is shared with supermarkets and other relevant stakeholders to ensure that all people identified as needing to shield have access to all services and support set up to support them.

413. To ensure that communication was provided to key stakeholders, Local Authority and Third Sector stakeholder forums were created to discuss any potential changes to the guidance before changes were published and that relevant information was included to all those on the Shielding Patient List in each letter. Emails were sent out to Local Authority and Third Sector stakeholders in advance of changes to shielding advice attaching a Q&A to assist stakeholders (and those they support) with any questions they may have. I attach an example of a Q&A which was sent to stakeholders on 15 July 2020 regarding the changes in shielding advice which applied from 16 July 2020 at **JPM3WGO02/143 - INQ000349771.**

414. In May 2020, at which point secondary care physicians were able add patients to the Shielding Patient List, the Welsh Government received communication from a charity that supports families who have children with Down's Syndrome expressing concern about the confusion that had arisen amongst this cohort due to recent receipt of letters to shield and then inconsistency between the GP and paediatrician as to whether the child did need to shield.

415. More generally, the Welsh Government took the following actions to ensure clarity amongst the patient group as to whether they fell within the clinical criteria or not and the changes to shielding guidance:

a. All those on the Shielding Patient List were notified of their status as soon as possible by letter, and key messaging was posted on social media including videos from the Chief Medical Officer for Wales.

b. A list of all the relevant conditions was included in the guidance that applied to all those on the Shielding Patient List.

c. On 3 April 2020, a public health link letter from the Senior Medical Officer was issued responding to patient queries to GPs regarding the letters to shielding patients at high risk. This letter, previously exhibited in **JPM3WGO02/140 - INQ000048588**. provided a response to several questions that had been raised, such as definitions of 'at risk' and 'at high risk', who had been written to, what patients should do if they haven't received a shielding letter. The letter also clarified the definition of severe asthma and whether the GPs or practices in Wales are expected to contact patients 'at risk'.

d. When additional conditions were added further into the pandemic, affected individuals were communicated to directly because of their medical condition. Any new medical conditions were also updated on the relevant guidance.

e. All queries received regarding shielding were sent to a dedicated email address and were responded to within 10 working days.

416. The Shielding Patient List continued to be updated during the pandemic as and when clinicians identified further patients required to shield, for example for those who received a new diagnosis after the initial letters were sent out. However, it became clear that the list was not always consistently updated, for example, when the requirements to shield were suspended and then re-introduced, some patients did not receive the shielding letter when they should have done, and others received the shielding letter when they were no longer required to shield due to a change in their medical status. The criteria for shielding was a rapidly evolving issue during the pandemic and the Welsh Government worked hard, alongside the NHS Wales Informatics Service (which later became Digital Health and Care Wales) and GPs to ensure that people who needed to shield were provided with a letter and clear advice. For example, when it was brought to the attention of the Senior Medical Officer for Primary Care that people with sarcoidosis and interstitial lung disease were not recognised on the Shielding Patient List, he wrote to GPs to ensure that these conditions were added. I exhibit a copy of the letter dated 1 June 2020 at **JPM3WGO02/144 - INQ000468989.**

417. The Welsh Government was also made aware of the following issues relating to changes to shielding guidance:

a. In July 2020, a significant number of children who had, up to then, been shielding, no-longer needed to shield due to Royal College of Paediatrics and Child Health guidelines. It was agreed that clinically these children did not need to shield, and the Welsh Government wrote to GPs and paediatricians informing them of the change, as exhibited at **JPM3WGO02/145 - INQ000469835**. A small number of schools refused to allow affected children to attend as they did not have proof that they no-longer needed to shield. A review was undertaken and families of children who were removed from the list were sent un-shielding letters, copied to their GPs. Families of children who were to remain on the list in the event of future shielding recommendations were sent shielding letters centrally.

b. On 17 August 2020, the Chief Medical Officer for Wales paused his advice to shield as infection rates were very low. Emails were received from individuals who were shielding asking for clarification. Communication was also received from some individuals who had not realised that they were on the shielding list until they were sent the letter that they no-longer needed to shield. In a number of cases this was because that individual had been added to the Shielding Patient List, after the initial letters were sent out, by their GP, secondary care clinician and in some cases from data provided by NHS England/NHS Digital of patients in England but who were resident in Wales.

c. On 22 December 2020 the advice to the clinically extremely vulnerable changed. They were advised to no longer attend work or school outside the home, particularly those whose work required them to be in regular or sustained contacted with other people or where individuals share a poorly ventilated workspace for long periods. Individuals who had previously been advised to shield did not all receive this letter. It was identified that at the beginning of the pandemic that many letters advising people to shield directly issued by their GP surgery or hospital clinician did not always result in the patients being added to the Shielding Patient List.

d. Individuals who had initially been on the Shielding Patient List and who had subsequently confirmed with their GP that they no longer were required to shield had also not been removed from the list. This meant that they then

received a letter in January 2021 advising them they needed to shield when in fact they were not required to do so.

e. There were challenges with preparing and issuing letters in adequate time due to the changing epidemiology of Covid-19. The Welsh Government ensured a process was in place to turn this around quickly and had a good working relationship with internal and external stakeholders to meet required deadlines. This was demonstrated in December 2020 when the Minister for Health and Social Services requested that those on the Shielding Patient List should follow shielding measures and not attend work and school. Letters were issued straight away prior to Christmas. Due to postal delays over the Christmas period the key content of the letter was further published in a 5 January 2021 Written Statement by the Minister, exhibited in **JPM3WGO02/146 - INQ000469068** to ensure that all those on the Shielding Patient List were aware of the changes to the advice.

f. In January 2021 it was identified that some children had not had their status downgraded as per the Royal College of Paediatrics and Child Health guideline when letters were sent out in August 2020 indicating that those children could be removed from the Shielding Patient List. 505 shielding letters were sent to children with Down's Syndrome despite them not being required to shield unless their doctor had specifically told them they needed to. This appears to have been because the data for under 18s had not been removed from the relevant file before it was sent to the printers. A letter was sent to parents to clarify that children with Down's Syndrome did not need to shield unless they had been advised to do so by their doctor. The letter dated 5 January 2021 is exhibited in **JPM3WGO02/147 - INQ000469066.**

Measures taken to ensure the shielding advice was accessible

418. Easy read versions of shielding guidance were published as follows:

a) An easy read version of the Initial guidance issued on 24 March 2020 (exhibited at **JPM3WGO02/148** - **INQ000080896**) was issued on the 1 April 2020, exhibited in **JPM3WGO02/149 - INQ000081032**.

b) Easy read versions of the 8 April 2020 updated guidance (exhibited at **JPM3WGO02/150** - **INQ000080982**) were published on 23 April 2020 and is exhibited at **JPM3WGO02/152 - INQ000081043.**

c) Further easy-read guidance was issued at the end of the firebreak period, on the 5 November 2020 on how to take extra care. This included the same advice as in the October guidance exhibited at **JPM3WGO02/153 - INQ000227258** with the addition of mask-wearing inside public places. A copy of this guidance is exhibited at **JPM3WGO02/154 - INQ000081602.**

d) The Chief Medical Officer for Wales wrote a letter on 27 July 2021 with advice for people who were clinically extremely vulnerable to provide guidance as the Covid -19 rules were relaxed. This strongly recommended the vaccine for those who had not been vaccinated 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 **JPM3WGO02/155 - INQ000271726.** An easy read version of this letter, also dated 27 July 2021, is exhibited in **JPM3WGO02/156** - **INQ000082194.**

e) All letters issued to those on the Shielding Patient List included information on how to request alternative versions, including audio, larger font size or translated versions, by emailing the main Shielding mailbox. These were issued as soon as they were completed by relevant contractors who specialised in providing these versions. The requests were logged and saved with the relevant guidance and the letter it referred to. Easy Read versions of letters were also published online when a letter was issued to all those on the Shielding Patient List.

f) When people with Down's syndrome were added to the Shielding Patient List, it was decided that they would primarily receive their update as a printed Easy Read letter, as exhibited in **JPM3WGO02/157 – INQ000469845.**

The impact of shielding on GPs' workload

419. I have been asked to describe any problems or concerns that came to the attention of the Welsh Government regarding increased operational pressure on general practitioners as a result of the use of the Shielding Patient List.

420. The Welsh Government was mindful of the potential impact that the imposition of shielding may have on GPs. Therefore, all preliminary work on identifying clinically extremely vulnerable 'shielding patients' was undertaken at national level, through

the Chief Medical Officer for Wales' office. Once the list of patients had been identified, and a letter sent, this list was then sent to GPs to check against their records and cross-refer to check if any of their highest risk patients needed to be added. Unfortunately, the letters to the 'shielding patients' were sent before GPs received the list of patients identified and as described above, a number of patient letters were initially sent to an incorrect address which caused concern and generated communication from GPs. Letters of communication were issued to GPs throughout the pandemic detailing any changes to advice and guidance for those on the Shielding Patient List.

421. It was inevitable that more people contacted their GPs on release of the Shielding Patient List and its updates. This was a period of rapid evolution, and inevitable questions arose from patients. During fortnightly calls with the General Practitioners Committee Wales and Royal College of General Practitioners and discussions on shielding it was stressed that when the Welsh Government made announcements on shielding, their workload increased due to patient contact.

422. Other specific instances of additional workload for GPs as a result of the shielding list were as follows:

   a. There was an early concern about 'missing' cross-border patients and the acknowledgement that this risked placing a disproportionate burden on GPs in these areas. The Welsh Government put in place mechanisms to identify and alert any patients who may have been missed.

   b. On 5 June 2020, Senior Medical Officer Dr Mark Walker wrote to GP practices to advise that shielding was being extended until 16 August 2020, having previously been due to end on 15 June 2020. The letter requested that GPs contact patients to check that they had received their shielding letter and provided guidance where a letter had not been received, check that the address of the patient was accurate, correct if necessary, and issue the patient with a copy of the Chief Medical Officer extension to shielding letter. The letter acknowledged that this was going to create additional work for GPs but highlighted the importance of this work for any future central distribution. The letter is exhibited in **JPM3WGO02/158 - INQ000468996.**

   c. On 30 July 2020, Dr Walker contacted GP practices to ask that they undertake a review of a small number of child patients who had been told to shield but

who, following Royal College of Pediatrics and Child Health guidance, no longer needed to. Whilst much of the work was being led by pediatricians there was a small exercise of review, cross reference and administration required by the GP practice. The letter is exhibited in **JPM3WGO02/159 - INQ000469035**. This work was later administered centrally, and GPs informed.

Inequalities

423. The Inquiry has asked me for information about inequalities. In order to address these questions, I have received support from Emma Coles (Deputy Director for Workforce).

Assessment of inequalities in the impact of the pandemic on NHS staff

424. The First Minister's Black, Asian, Minority Ethnic Covid-19 Advisory group ("the Advisory Group") was convened on 29 April 2020 and met until 20 April 2021. The group was established in response to early concerns that there were disproportionately high Covid-19 deaths in Black, Asian and Minority Ethnic groups, and to advise the First Minister and his Cabinet on such matters. The Advisory Group was co-chaired by Judge Ray Singh CBE and Dr Heather Payne, a senior medical officer in Welsh Government.

425. The group included representation from Welsh Government officials; Black, Asian, Minority Ethnic NHS and care workers; 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.

426. The Advisory Group was supported by analysis of a range of statistical data available about the circumstances of the Black, Asian and Minority Ethnic group population in Wales which was published by the Welsh Government in a statistical article "Coronavirus (Covid-19) and the Black, Asian and Minority Ethnic (BAME) population in Wales". I exhibit a copy of the article dated 22 June 2020 at **JPM3WGO02/160 - INQ000081237**.

427. Although the Advisory Group was not exclusively focused on the impact of the pandemic on Black, Asian and Minority Ethnic NHS staff, a key driver for the genesis of the Advisory Group was the evidence which suggested the disproportionately high rate of ethnic minority individuals among health and care

workers who died from Covid-19 and thus highlighting the need to protect the NHS and social care workforce, the backbone of the pandemic response.

428. Two subgroups were established as part of the Advisory Group, the Socio-economic subgroup chaired by Professor Emmanuel Ogbonna and the Workforce Risk Assessment subgroup chaired by Professor Keshav Singhal. The purpose of the Socio-economic subgroup was to advise on socio-economic factors and wider social determinants influencing Covid-19 health outcomes in Black, Asian and Minority Ethnic people. Whereas the purpose of the Workforce Risk Assessment subgroup was to make recommendations to the Advisory Group on workplace risk assessment for frontline health and social care workers in Wales and suggest practical steps to mitigate the risk for the staff identified as vulnerable.

429. I have exhibited the terms of reference for the Advisory Group, the Socio-economic subgroup and the Workforce Risk Assessment subgroup at **JPM3WGO02/161 – INQ000066077**. 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 address the impact of the pandemic on the vulnerable populations.

430. I exhibit a summary report of the Advisory Group which was published in September 2021 at **JPM3WGO02/162 - INQ000066078,** describing the creation and work of the subgroups as set out above. I have provided further information on the outcomes of the subgroups below.

Workforce Risk Assessment subgroup

431. I have exhibited the report of the Workforce Risk Assessment subgroup published in October 2021 at **JPM3WGO02/163 - INQ000282020** which set outs the work and findings of the Risk Assessment subgroup.

432. In summary, the Workforce 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, including SAGE papers, Office for National Statistics dataset analyses of coronavirus-related deaths by ethnic group, health conditions, and by occupation, as well as papers from the faculty of Occupation Medicine, the British Medical Association and from the United States of America. The group concluded that it was a combination of various factors which contributed to the severity of infection including age and ethnicity.

433. The work of the Workforce Risk Assessment subgroup 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 all health and social care staff. The Tool included signposts to health and wellbeing resources as well as the behaviours to avoid Covid-19 infection. I have exhibited a copy of the first version of the All Wales Covid-19 Workforce Risk Assessment Tool which was launched on 27 May 2020 at **JPM3WGO02/164 - INQ000299409.** I have provided further information on the All Wales Covid-19 workforce Risk Assessment Tool below.

434. The Workforce Risk Assessment sub-group continually refined the Workforce Risk Assessment Tool in light of new and emerging clinical evidence on the impact of Covid-19 on the population of Wales and particularly on those with protected characteristics. The Workforce Risk Assessment sub-group closely monitored the risk levels of all NHS staff using data regularly provided by Health Education and Improvement Wales on completed risk assessments. Data returns included the cumulative total number of assessments completed by each Local Health Board and NHS Trust against the category of risk.

Socio-economic subgroup

435. I have exhibited a copy of the report of the Socio-economic subgroup published in June 2020 at **JPM3WGO02/165 – INQ000227599** which set outs the work and findings of the Socio-economic subgroup**.**

436. In summary, the report highlighted the entrenched inequalities experienced by ethnic minority people which were magnified by Covid-19. As regards NHS workers, the report noted that there was Black, Asian and Ethnic Minority people were over-represented in some sectors of the NHS and identified such workers as an at-risk group for Covid-19. The report also noted evidence regarding Black, Asian and Ethnic Minority members of staff experiencing racism within the NHS and reports of such members of staff feeling pressurised to work on Covid-19 wards and with a lack of PPE. The evidence base for its finding was drawn from information, reports, briefings and insights sent to the Welsh Government and I attach a high level summary of such evidence at **JPM3WGO02/166 – INQ000353878.**

437. The report made 37 recommendations, of which the following related to NHS staff:

a) Ensure wide dissemination of the All Wales Covid-19 Workforce Risk Assessment Tool backed by robust employer and employee advice in a range of formats, supported by clear and time-bound communication and stakeholder engagement plan – and encouragement of use of the tool in settings wider than health and social care. Safeguard mechanisms should also be built into the system to ensure that individuals are not affected adversely by the results of the assessment.

b) Employees that are classified as High to Very High Risk under the All Wales Covid-19 Workforce Risk Assessment Tool should not have a reduction in their wages/salary/income as a result of being removed from frontline duty or being re-deployed to a different area of Low-Risk work.

c) Regular reviews must be taken to add value to the already launched risk assessment tool and make future recommendations on its enhancement. Employers should be signposted to support on how to use the risk tool and be mandated to implement this as part of their employment practice beyond the Covid-19 crisis. Employers should be mandated to stockpile and provide adequate PPE for any future risk to employees.

d) Address any unfair or illegal discrimination at work in, or by users of, the NHS in Wales, through renewed attention to anti-oppressive practices, equality and diversity competences, documenting lived experiences of Black, Asian and Minority Ethnic workers, and systematic Equality Impact Assessments specific to ethnicity. I am not aware of any Equality Impact Assessments that were undertaken on that matter following this recommendation.

e) 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 Black, Asian and Minority Ethnic Staff members to express concerns without the threat of unfair action by Line Managers and above.

f) Provide a dedicated and continuous support helpline and a confidentiality framework in workplace guidance, so employees can challenge safely and raise concerns. This would allow workers to report PPE and other concerns with confidence and could provide a model for use in wider employment contexts.

438. On 24 September 2020, the First Minister gave a detailed response to the report and its recommendations as exhibited in **JPWGO02/167 - 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.

Guidance or advice to providers of NHS services in Wales regarding individual risk assessments for staff

439. As set out above, the Workforce Risk Assessment Subgroup produced an All Wales Covid-19 Workforce Risk Assessment Tool. This was a tool designed to help people working in the NHS and Social Care in Wales to understand if they are at higher risk of developing more serious symptoms if they come into contact with the Covid-19 virus, by asking a number of questions such as health, weight and ethnicity. The answers were scored depending on the level of risk. An overall score of 0 - 3 was deemed a low risk, 3.5 – 6 was deemed a high risk, and 6.5 or more a very high risk. The Tool also provided information and guidance to support individuals to understand their overall score and what this mean in terms of their risk, and to have a supportive and structured conversation with their line manger to discuss their level of risk to put in place actions to ensure they are protected as far as possible. This may include additional protection, changing work practices or working from home. The Tool also included signposts to health and wellbeing resources as well as the existing and continuing behaviors to avoid Covid-19 infection.

440. I have exhibited the written statement issued by the then First Minister of Wales, Rt Hon Mark Drakeford, on 27 May 2020 announcing the introduction of the All Wales Covid-19 Workforce Risk Assessment Tool to the NHS and social care at **JPM3WGO02/168 - INQ000023243.** I also exhibit a copy of the first version of the All Wales Covid-19 Workforce Risk Assessment Tool which was launched on 27 May 2020 and exhibited earlier at **JPM3WGO02/164 - INQ000299409**.

441. As evidenced at paragraphs 3.5 and 3.6 of the minutes of the meeting of the Risk Assessment subgroup of 27 May 2020, the All Wales Covid-19 Workforce Risk Assessment Tool was shared with Local Health Boards, and it was advised that only the new Tool was to be used going forwards. I exhibit a copy of the minutes of the meeting of the Workforce Risk Assessment subgroup at **JPM3WGO02/169 - INQ000282058**. The Welsh Government's Chief Nursing Officer also promoted the

use of the Tool through social media, and the NHS in Wales also made an electronic version of the Tool available on its e-learning platform.

442. As mentioned earlier in this statement, the All Wales Covid-19 Workforce Risk Assessment Tool was considered a live resource that was subject to ongoing review and evaluation by the Workforce Risk Assessment Subgroup, with changes made depending upon new evidence and any lessons learned from implementation. The Welsh Government ensured that the latest version of the Tool was available on its website, and that the health organisations in the NHS were made aware of any changes made. By way of examples of the changes made, I exhibit copies of the All Wales Workforce Tool published on:

    a) 29 May 2020 as exhibited earlier at **JPM3WGO02/164 - INQ000299409.** These amendments reflect updated advice on Black, Asian and Ethnic Minority women who were pregnant.

    b) 18 June 2020 exhibited earlier at **JPM3WGO02/170 - INQ000469854**. This makes amendments to the risk matrix table in relation to high risk and secondary care with AGP; and

    c) 7 August 2020 at **JPM3WGO02/171 - INQ000355860**[46]. These amendments reflect updated guidance for the extremely vulnerable 'shielded' group.

443. The All Wales Covid-19 Workforce Risk Assessment Tool was further amended to suit the context of different workplaces, with a sector specific version available for Education as well as a more generic version for other sectors.

444. To facilitate and support the use of the All Wales Covid-19 Workforce Risk Assessment Tool, the Welsh Government also published a guidance document for managers and staff, FAQs and an Easy Read version of the All Wales Covid-19 Workforce Risk Assessment Tool. By way of example of those documents, I exhibit:

    a) the Guidance for Managers and Staff published on the Welsh Government website on 2 July 2020 at **JPM3WGO02/172 - INQ000469856**,

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[46] 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 [INQ000469049]

b) FAQs published on the Welsh Government website on 6 July 2020 at **JPM3WGO02/173 - INQ000469857**, and

c) The easy read version of All Wales Covid-19 Workforce Risk Assessment Tool published on the Welsh Government website on 26 October 2020 at **JPM3WGO02/174 - INQ000469858**.

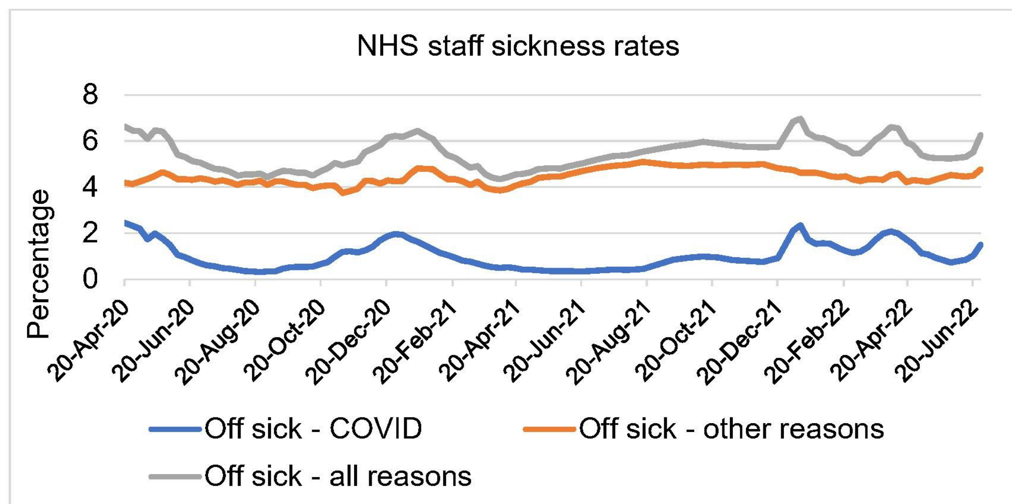
445. Between 11 January 2021 and 12 February 2021, the Welsh Government ran a survey of the All Wales Covid-19 workforce risk assessment tool in order to gain a better understanding of the Tool in terms of the ease of use, whether the Tool has led to a change in working practices and the extent to which the Tool is perceived to accurately capture the risk of Covid-19. I exhibit the report of that survey at **JPM3WGO02/175 - INQ000469859.** That report found that: most respondents found the All-Wales Covid-19 workforce risk assessment tool to be easy, simple and straightforward; almost a quarter of respondents considered that the completion of the tool led to a change in working practices; and just under two-thirds of respondents considered the risk assessment score they obtained via the tool to be accurate.

446. QCOVID was not used in NHS settings in Wales because it had not received a licence as a validated medical device at the time it would have been needed at the beginning of the pandemic. Instead, the Welsh Government developed the All Wales Covid-19 Workforce Risk Assessment Tool which was widely used across the NHS in Wales.

Sickness amongst NHS staff

447. I have provided a graph below showing the number of NHS staff who were off sick due to Covid-19 during the relevant period.

Figure 6 Graph showing NHS staff sickness rates



448. Although Welsh Government regularly received data on the number of NHS staff absences for reasons due to Covid-19. This data did not include, and the Welsh Government does not now hold, the number and percentage of NHS staff who contracted Covid-19 whilst at work and therefore the graph does not give any information about the source of contraction. Furthermore, the Welsh Government does not hold or publish official or verified data on the number of NHS staff who died from Covid-19. Information on the number of healthcare workers who died from Covid-19 was published by the Office for National Statistics and may also be held by the Health and Safety Executive via the information provided to it by employers in Wales in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations ("RIDDOR"). The RIDDOR requires employers to report cases of disease or death from Covid-19 to the Health and Safety Executive where an employee had been infected with coronavirus through exposure to the virus whilst at work.

Recording of patient deaths

449. The Inquiry has asked me for information about the recording of patient deaths. In order to address these questions, I have received support from Stephanie Howarth, (Chief Statistician).

Explanation of the information published by the Welsh Government on the deaths of patients in hospital from Covid-19

450. The Welsh Government did not produce its own Covid-19 mortality data during the relevant period and instead relied on data from the following two sources:

a) The rapid surveillance data around deaths collected by Public Health Wales via its e-Form and published on a daily basis; and

b) Data regarding deaths, as ascertained from death certificates where Covid-19 was mentioned, published weekly by the Office for National Statistics.

451. I have set out further information on these sources below.

Rapid surveillance data around deaths collected by Public Health Wales

452. The rapid surveillance data around deaths published by Public Health Wales was obtained from information provided to Public Health Wales by Local Health Boards and NHS Trusts on deaths relating to Covid-19. This was in pursuant the Covid-19 Death Protocol which was issued on 22 March 2020 by Welsh Government and required that the "treating clinician informs" Public Health Wales of any deaths of hospitalised patients where Covid-19 had been confirmed with a positive laboratory test and the clinician suspects that Covid-19 was a causative factor. I exhibit a letter sent by Dr Andrew Goodall to Chief Executives of Local Health Boards on 23 April which includes the Covid-19 Death Protocol in Wales published on 25 March 2020 at **JPMWGO02/176 - INQ000469241.**

453. Given the delay in the availability of data on deaths from the Office for National Statistics due to the reliance on the formal death registration process and coroner's reports, the Public Health Wales surveillance data provided a timely mechanism to ensure data are available to inform the public on the scale of the outbreak and to rapidly identify trends in mortality and inform modelling. It was not intended to be used as a complete and accurate source of all deaths as it largely focused on deaths in hospitals and related only to deaths where Covid-19 had been confirmed with a positive laboratory test.

454. Systematic under-reporting in the Public Health Wales rapid surveillance data was identified during the early stages of the pandemic. I exhibit a review undertaken by

the Welsh Government dated 27 April 2020 which sets out a number of actions initiated by the Welsh Government with the aim of improving the reporting process at **JPM3WGO02/177 - INQ000395663**. An enhanced programme of assurance was put in place following this review.

Data around deaths produced by the Office for National Statistics

455. The data published by the Office for National Statistics intended to capture all deaths from Covid-19 and throughout the relevant period this data was considered the authoritative picture of Covid-19 mortality. Mortality data was published by Office for National Statistics on a weekly basis and would regularly include a breakdown of data by place of death (e.g. hospital, care home, private home).

456. Office for National Statistics mortality data is based on death registrations and coroner's reports. The doctor certifying a death can list all causes in the chain of events that led to the death and pre-existing conditions that may have contributed to the death. A doctor may certify the involvement of Covid-19 based on symptoms and findings; a positive Covid-19 test result is not required. Using that information, the Office for National Statistics determines an underlying cause of death. Office for National Statistics uses the term "deaths due to Covid-19" when referring only to deaths with an underlying cause of Covid-19. Whereas Office for National Statistics uses the term "deaths involving Covid-19" to refer to deaths that had Covid-19 mentioned on a death certificate, whether as an underlying cause or not.

457. The Office for National Statistics data also included deaths from causes other than Covid-19. This enabled the Welsh Government to estimate "excess" deaths – i.e. the difference in the number of deaths compared with the average for the previous 5 years.

Publication of data by the Welsh Government

458. From April 2021, the Welsh Government's Knowledge and Analytical Services published a weekly dashboard which included information on deaths involving Covid-19 in Wales, which included both Public Health Wales and Office for National Statistics data. Both sources were used in view of the differing strengths and limitations of the two data sets as set out above. The dashboard did not include any data specifically about place of death (e.g. hospital, care home).

459. The Chief Statistician at the time, Glyn Jones, published an article explaining the Covid-19 mortality sources for Wales on 5 May 2020. I exhibit a copy of the article at **JPM3WGO02/178 - INQ000299980.**

460. During the course of the relevant period, the Technical Advisory Group published three reports examining Covid-19 related deaths in Wales, which included information on place of death using Official for National Statistics mortality data. I exhibit a copy of the report dated 15 July 2020 at **JPM3WGO02/179 - INQ000252526**, dated 24 March 2021 at **JPM3WGO02/180 - INQ000252532** and dated 30 March 2020 at **JPM3WGO02/181 - INQ000066370.**

General practice

461. The Inquiry has asked me for information about general practice. In order to address these questions, I have received support from Alex Slade (Director of Primary Care and Mental Health) and Paul Casey (Deputy Director of Primary Care and Mental Health).

Guidance or advice for GPs regarding changes to primary care in response to the pandemic

462. The Inquiry has asked me to outline any guidance or advice for GPs produced or disseminated by or on behalf of the Welsh Government regarding changes to primary care in response to the Covid-10 pandemic. I have set these out below.

Use of technology to enable remote appointments

463. Prior to the pandemic the Welsh Government funded a Technology Enabled Care Programme ("TEC") based within Aneurin Bevan University Health Board to assist in the development of digital services across health and social care. This was in line with "A Healthier Wales" which envisages citizens being able to be cared for away from a health setting and allowing a greater emphasis on self-care and remote management. The aim of the Technology Enabled Care Programme is to prevent, manage and control harm or illness, slow down the progression of care needs and maintain and promote independence in the home and community. Part of the TEC included the development of a pilot video consultation service using the "AttendAnywhere" platform, which is a web-based video consultation system that has 'virtual' waiting rooms that patients wait in before being seen by a clinician remotely. It requires both users (patients and clinician) to have access to either a computer with

Google Chrome or Safari web browser and a webcam, a mobile device running iOS or a mobile device running Android. It did not record or archive the consultation or record any patient data, meeting the strict requirements of handling patient information. The Technology Enabled Care Programme Cymru had piloted AttendAnywhere in out of hours GP services and secondary services in the ABUHB area with great success. Scottish Government had also piloted the service, branded as 'Near Me' through the Digital Health and Care Scotland programme.

464. On 11 March 2020, the Minister for Health and Social Services, Vaughan Gething, announced the expansion of the pilot system to a national video consultation service across all 404 GP practices in Wales. I have exhibited a copy of the written statement dated 11 March 2020 at **JPM3WGO02/182 – INQ000469843**. The aim of the national rollout was to assist in the reduction of the spread of the infection of Covid-19 amongst patients and staff, and to allow patients in self-isolation to maintain face-to-face contact with medical professionals. It was also recognised that the service would allow GPs to continue to hold consultations with patients should they need to self-isolate and thereby reducing the strain on the wider healthcare system. The 'Near Me' service in Scotland was also expanding at pace at this time, as did a video consultation service run through NHS England using the AttendAnywhere platform. Technology Enabled Care Programme Cymru worked closely with both the Scottish programme and the English programme during the rollout to share learning. Accordingly, the rollout of the national video consultation service was in alignment with the actions taken by the other nations. I have also exhibited a copy of the announcement that was made on the Welsh Government's website regarding the rollout of the service at **JPM3WGO02/183 - INQ000469199.**

465. Much of the technical infrastructure to enable the rollout of the national video consultation service was already in place across GP practices in Wales. The Welsh Government also invested in a remote desktop solution led by NHS Wales Informatics Service that enabled GPs to access surgery computers remotely via their own personal computers to ensure that, where GPs could not access surgeries due to suspected infections or travel restrictions, they could still undertake work from home with access to patient records.

466. On 11 March 2020, the then Chief Executive of NHS Wales, Dr Andrew Goodall, wrote to all General Practitioners, Local Health Boards and the Welsh Ambulance Services NHS Trust to update on the Covid-19 response. I have exhibited a copy of

the letter at **JPM3WGO02/184 - INQ000395690.** The letter noted that a lot of work had been undertaken to procure a videoconferencing consultation function so that practices and patients have the option to have virtual surgeries. As set out in the letter, it was not intended to replace physical assessment but that such assessments would be more targeted, with consideration given to vulnerable groups and to those persons without internet access.

467. It was anticipated that the first phase of the roll out would see all 80 GP practices across the area for Aneurin Bevan University Health Board, with the second phase of the roll out being to the remainder of GP practices across Wales. I have exhibited an Implementation Evaluation Report dated 20 March 2020 at **JPM3WGO02/185 – INQ000469269** which sets out the number of surgeries in Gwent which had access to the video consultation service at that time and some patient testimonials. I have also exhibited a copy of the minutes of the Health and Social Services Group Digital Cell dated 30 March 2020 at **JPM3WGO02/186 - INQ000468923** which confirmed that the roll out of the video consultation service had been rolled out to Aneurin Bevan University Health Board area and including Out of Hours GP services, and that the rollout of the service to the rest of Wales was undergoing testing and ready to be configured on 1 April 2020.

468. From 1 April 2020, all GP practices in Wales were able to access the video consultation service and I exhibit a copy of the press statement issued by the Welsh Government confirming this on 1 April 2020 at **JPM3WGO02/187 – INQ000469197.** All training on the video consultation service was given by the Technology Enabled Care Programme Cymru, who also worked with the Life Sciences Hub Wales to encourage GP practices to adopt the technology via direct messaging to GPs and on social media and through the press.

469. As cases of Covid-19 eased during the relevant period, the Welsh Government did not mandate a blanket return to face-to-face appointments. Instead, the Welsh Government's policy approach endorsed a blended model of access with a mix of remote, face to face, urgent, on the day and pre-bookable appointments, as determined by the practice in discussion with the patient. This is reflected in the Access Commitments which were introduced by the Welsh Government from 1 April 2022 and exhibited at **JPM3WGO02/188 - INQ000469272**.

470. The Welsh Government does recognise however that there can be limitations associated with remote consultations. This is illustrated in the Welsh Health Circular issued by the Chief Medical Officer for Wales on 4 August 2020 exhibited at **JPM3WGO02/189 – INQ000048607** in which he outlined his concerns that the emphasis on remote consultation may make it more difficult for GPs to assess the severity of Covid-19 illness. The Chief Medical Officer for Wales also outlined his concerns that breathlessness is not a good indicator of disease severity and asked that clinicians place a greater emphasis on measuring pulse oximetry as part of their clinical assessment but that the use of remote monitoring of pulse oximetry was not recommended at that time. As a result, changes were made to the public messaging and the Community Covid-19 Framework, which was a framework designed to support primary care, community and paramedic colleagues in decision making regarding the managing of patients with Covid-19. Previously in this statement I have exhibited a copy of the Community Covid-19 Framework dated 23 March 2020 at **JPM3WGO02/134 – INQ000226967** and the updated Community Covid-19 Framework dated 16 June 2020 at **JPM3WGO02/135 – INQ000227398**. The Community Covid-19 Framework was fully replaced in December 2020 with an All Wales Guideline for the Management of patients with confirmed or suspected Covid-19 in the Community. I have exhibited the Welsh Health Circular dated 22 December 2020 which outlines the introduction of the All Wales Guideline at exhibit **JPM3WGO02/190 – INQ000227396** and a copy of the All Wales Guideline itself at **JPM3WGO02/191 – INQ000469860**. Key developments in the December 2020 Guideline guidance included:

a) The widespread use of COVID-19 community testing, meaning that primary care clinicians are seeing more patients with proven diagnosis.

b) The ability to segment patients with proven or suspected COVID-19 into three risk categories with separate recommended actions.

c) The potential to use pulse oximetry to support self-monitoring at home for patients at moderate risk of complications.

d) The availability of clear thresholds for admission or staying at home with safety-netting advice.

e) 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.

Triaging of patients prior to consultation

471. On 17 March 2020 the Deputy Director of the Primary Care Division at Welsh Government, Alex Slade, wrote to all GP practices outlining a number of measures to be taken to minimise attendance at GP surgeries in order to slow the spread of the virus and to keep the public and healthcare workers safe. One of the measures included encouraging GP practices to put in place arrangements to ensure no patient arrives at a surgery without having had an appropriate triage. Bookings for appointments would either be done via the telephone or My Health On-line (an online service for booking GP appointments), and triaging would be undertaken by a senior clinician who is appropriately skilled to deal with the issue by telephone or video consultation, or by whomever can most effectively decide who needs a physical assessment. Furthermore, GP practices were required to contact any patients who had a booked appointment to attend the surgery to assess whether they had symptoms indicative of Covid-19 and triaged accordingly. I have exhibited a copy of the letter at **JPM3WGO02/192 - INQ000468912**.

472. These triaging requirements remained in place for the entirety of the relevant period.

The provision of in-person consultations

473. A key objective of the triage process was for a clinician to decide who needed a physical or in-person assessment, as opposed to a remote consultation (either by telephone or the video consultation service). Accordingly, in-person consultations continued to be provided during the relevant period based on patient need, including where the patient was in a vulnerable group, or they did not have internet access. This is set out in a letter sent from Dr Andrew Goodall to GP practices on 11 March 2020 and exhibited earlier at **JPM3WGO02/184 - INQ000395690**.

Changes to home visits including GP visits to residential care facilities

474. Prior to the onset of the Covid-19 pandemic in March 2020, GP contractors who had agreed to provide "enhanced services" as part of their GMS contracts were required to operate a Care Home Scheme. I exhibit a copy of the Primary Medical Services (Care Homes) (Directed Enhanced Services) (Wales) Directions 2017 at **JPM3WGO02/193 - INQ000469276** which sets out the requirements of the Care

Home Scheme. The scheme ensured that GP contractors undertook a proactive approach to caring for people registered with their practice and living in a care home, to carry out activities such as undertaking a review of their mental and physical health within 28 days of the resident moving into the care home and to undertake further reviews as clinically appropriate. The Scheme was considered an "enhanced" service rather than an "essential service". Enhanced services require the contractor to provide an enhanced level of service provision under the contract in accordance with specifications set out in a plan, whereas essential services are what every contractor has to provide to its patients.

475. The arrival of the Covid-19 pandemic in March 2020 resulted in a review of all General Medical Services activity. On 17 March 2020, Dr Andrew Goodall wrote to the Chief Executives of Local Health Boards requiring them to suspend certain enhanced services such as the Care Home Scheme. This intention behind the suspension of the Scheme was to reduce all non-essential contact for infection control purposes, and to ease pressure on the system to prepare for an increase in Covid-19 cases. I exhibit a copy of the letter sent by Dr Andrew Goodall at **JPM3WGO02/194 - INQ000252810**[47]. In that letter, Dr Andrew Goodall gave the following advice to GMS contractors in relation to the Care Home Scheme:

> *Suspend. Consider DNA, CPR and TEPs assessments and give particular consideration given the vulnerability of these groups. Reduce all non-essential visits.*

This advice was in place until the new scheme was introduced on 1 July 2020 which is set out in further detail below.

476. The prevalence of Covid-19 and mortality rate within care homes came into sharp focus during mid-April 2020, and led the Welsh Government to establish a Care Home Task & Finish group (terms of reference are exhibited at **JPM3WGO02/195 - INQ000469193**) which reported into the Primary and Community Care Group to ensure that optimal consistent primary medical care in care homes was provided during the Covid-19 pandemic.

477. I exhibit an advice note prepared by the Care Home Task & Finish Group dated 6 May 2020 and sent to the Executive Directors Team of the Health and Social Service

[47] 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 [INQ000227120]

Group at **JPM3WGO02/196 - INQ000353532**. The purpose of that paper was to advise on problems identified, recommend solutions to ensure optimal consistent primary medical care in care homes during the Covid-19 pandemic and to ensure the Primary and Community Care Group that the primary care received by care home residents in Wales is the best it can be in the coming weeks. One of the problems identified was a widespread perception that access to general practice was harder than before the pandemic, and recommended solutions included: requiring GPs to lead the clinical response in care homes; requiring GPs to offer to physically visit each care home at least once a week; requiring GPs to conduct more frequent ward rounds over video consultation; reminding GPs of their duties under the GMC guidance; and also require GPs to work with care home managers to reduce the numbers of clinicians and community staff that need to visit care homes during the pandemic. I also exhibit a letter sent from Dr Andrew Goodall to NHS Wales Chief Executives in May 2020 notifying them of the recommendations of the Task and Finish Group at **JPM3WGO02/197 – INQ000468986**.

478. The work of the Care Home Task & Finish Group provided the foundation for negotiations with the British Medical Association on how general practice could continue to deliver high quality care and support to care homes and their residents during the Covid-19 pandemic. As a result, the Welsh Government, the British Medical Association and Local Health Boards agreed that the Care Home Scheme should be refocused to address the support needed during the Covid-19 pandemic with a revised service specification. The Covid-19 Care Homes Scheme is set out in the Primary Medical Services (Covid-19 Care Homes) (Directed Enhanced Services) (Wales) Directions 2020 which came into force on 1 July 2020 and is exhibited at **JPM3WGO02/198 – INQ000469013**. These Directions enabled Local Health Boards to commission GP contractors to operate a Covid-19 Care Home Scheme, the purpose of which was to: optimise access to primary medical care for registered patients who reside in care homes; enable urgent access to primary medical care advice for care home staff; and ensure GMS contractors take a pre-emptive, proactive and anticipatory approach to caring for registered patients residing in a care home. This included a requirement on GP contractors to provide structured clinical consultations to care home residents, including consultations in person at the care home premises or, if appropriate, remotely via audio-visual technology.

479. I exhibit a 17 June 2020 letter sent from Deputy Director for Primary Care Division, Alex Slade, to Directors of Primary Care and Community Care which informs of the

coming into force of the Primary Medical Services (Covid-19 Care Homes) (Directed Enhanced Services) (Wales) Directions 2020 at **JPM3WGO02/199 - INQ000469277**.

480. I also exhibit a copy of the Covid-19 Care Homes Scheme Directed Enhanced Service Specification at **JPM3WGO02/200 – INQ000469019.** This sets out that the aim of the Covid-19 Care Home Scheme during the period of the Covid-19 pandemic was to optimise access to primary medical care for care home residents, enable urgent access to primary medical care advice for care home staff, continue provision of pre-emptive proactive and anticipatory care, and promote a high quality consistent approach across Local Health Boards whilst at the same time being flexible enough to be adopted by clusters or individual practices. It also sets out further detail on the requirements of GPs in operating the Covid-19 Care Home Scheme which included: regularly and effectively engaging with care home staff in the comprehensive management of care home residents on a weekly basis followed up where necessary with structured clinical consultations to care home residents; allow GPs to support a multi-disciplinary team to provide comprehensive management of care home residents and ensure appropriate assessments are completed; and work with the cluster lead practice, local GP practices and care home managers to reduce the number of clinicians and community staff that need to visit care homes during the Covid-19 pandemic, e.g. by streamlining patient registration policies where it will benefit care to residents whilst preserving and respecting residents' choice. The Specification also sets out payments to be made to GPs in delivering the service, and monitoring arrangements, and noted: *"The suspension of the DES [the Care Homes Directed Enhanced Service] did not detract from the need for practices to continue to support care homes and residents of care homes are entitled to access essential services the same as any other registered patients."*

481. I am not aware of any guidance given by the Welsh Government on visits by GPs to patients in their own homes (not including care homes).

Advance care plans and Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR") notices

482. 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 Strategic Group, which was established to sit under the NHS Wales End of

Life Care Board and the Deputy Chief Medical Officer for Wales for the purposes of providing clear leadership and strategic direction for all aspects of Advance Future Care Planning reviews and updates this policy every two years, most recently in April 2022. The policy in place at the start of the pandemic was the 2017 and exhibited in this statement at **JPM3WGO02/200a - INQ000227411**. The policy in place between 2020 and 2022 was exhibited earlier in **JPMWGO02/139a - INQ000283301**. This updated policy included 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, additional resources for patients and their loved ones considering DNACPR, the requirements and responsibilities of the senior responsible clinician with oversight, and organ donation.

483. On the 28 March 2020 the Chair of the Advance Future Care Planning Strategic Group and the Clinical Lead of the End of Life Care Implementation Board wrote out to all Medical Directors, Nursing Directors and the Welsh Ambulance Services Trust to confirm that the all Wales DNACPR policy was being reviewed however, recognising significant concerns 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 at **JPM3WGO02/200b - INQ000226990** and this was shared with the Deputy Chief Medical Officer for Wales who agreed the wording before the letter was issued.

484. In addition to the policies set out above, the Welsh Government was made aware of guidance developed by the Royal College of General Practitioners which provided specific advice to GPs on the topic of advance care planning. The Welsh Government did not have any involvement in the development of that guidance, which was sent directly from the Royal College of General Practitioners to Local Health Boards with a request that they issue to GP practices within their area. I have exhibited a copy of the guidance entitled "Having Sensitive Conversations and Advance Care Planning" at **JPM3WGO02/201 - INQ000412481**. This guidance outlined that groups of individuals who are at increased risk of severe illness from coronavirus may benefit from Advance Care Planning, provided practical guidance on contacting and speaking with such individuals about Advance Care Planning, and endorsed the RED-MAP framework to guide discussions about Advance Care Planning which stands for: Ready; Expect; Diagnosis; Matters; Actions; Plan. Depending on how the conversation progressed, the guidance also outlined that GPs may also wish to

explore with their patient other relevant aspects of advance care such as wishes regarding CPR and the issuing of a DNACPR form.

Referral of patients to secondary care

485. On 23 March 2020, Dr Andrew Goodall issued a letter to Chief Executives of Local Health Boards and the Welsh Ambulance Services Trust attaching the Community Covid-19 Framework which was intended to support primary care, community and paramedic colleagues in decision making regarding the management of patients presenting with suspected or actual Covid-19. This included an agreed national respiratory pathway for managing Covid-19 in the community and referral/admissions of Covid-19 positive patients to hospital. I exhibit a copy of the letter dated 23 March 2020 at **JPM3WGO02/202 – INQ000226961.** The Community Covid-19 Framework dated 23 March 2020 is previously exhibited at **JPM3WGO02/134 – INQ000226967.**

486. As set out earlier in my statement, the Community Covid-19 Framework was subsequently updated on 16 June 2020 (previously exhibited at **JPM3WGO02/135 – INQ000227398**), before being fully replaced in December 2020 with an All Wales Guideline for the Management of patients with confirmed or suspected Covid-19 in the Community (announcement previously exhibited at **JPM3WGO02/190 – INQ000227396** and the guidance exhibited at **JPM3WGO02/191 – INQ000469860**).

487. As regards other referrals to secondary care for healthcare issues unrelated to Covid-19, Dr Andrew Goodall issued a letter to the Local Health Boards and NHS Trusts in response to an issue raised by the British Medical Association regarding concerns that Local Health Boards were not accepting routine primary care referrals. In his letter, Dr Goodall outlined that consistent use of referral process and communication information was important to ensure a standard referral process for all patients across in Wales and provided a process flow chart and guidelines for the handling of outpatient referrals during the pandemic and a number of standard letters and patient information sheets. I have exhibited a copy of the letter, and the guidelines at **JPM3WGO02/203 – INQ000262315**[48] and **JPM3WGO02/204 – INQ000262310**[49]**.** The guidelines state that, before referral, healthcare professionals in primary care

[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 [INQ000227119]

[49] 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 [INQ000469190]

and community-based services should consider local alternatives to referral, which may include phoning a telephone advice line offering a specialist opinion; written advice from a specialist; or local advice from a GP with an extended role or special interest in the relevant specialty. Referrers should also ensure sufficient information is provided in the referral letter for the triage clinician in secondary care to be able to adequately assess the priority of the patient's need.

488. The Welsh Government also funded the use of 'Consultant Connect' across the NHS in Wales to support GPs and paramedics to directly contact the right specialists in hospitals and avoid direct admissions where possible. This also involved the direct commissioning of the service by Welsh Government. This was then rolled to all Local Health Boards, and they were able to access the services from Consultant Connect from April 2020.

Management of patients with long-term health conditions

489. On 12 March 2020, the Welsh Government's Deputy Director for Primary Care, Alex Slade, sent a letter to Directors of Primary and Community Care advising that, as a precautionary measure to help ensure the uninterrupted supply of medicines to patients in the UK, manufacturers had been asked to retain any medicine stockpiling arrangements put in place in preparation for EU exit. It was emphasised that GPs should continue to act responsibly and consider the potential consequences for patients that might arise from taking any local action that might adversely affect the medicine supply, including stockpiling medicines or increasing prescription durations as they would have an impact on the supply for other patients. I exhibit a copy of the letter at **JPM3WGO02/205 - INQ000227418.**

490. In the letter sent from Dr Andrew Goodall to Chief Executives of Local Health Boards on 17 March 2020 exhibited earlier at **JPM3WGO02/194 – INQ000252810,** Dr Goodall outlined the enhanced services which should be suspended in order to ease pressure on the system in response to the pandemic. These included the suspension of routine monitoring for some long-term health conditions in stable patients. These suspensions were revoked in the Directions as to Local Health Boards as to the Statement of Financial Entitlements (Provision of Enhanced Services during the Recovery Phase of the Covid-19 Pandemic) Directions 2020 which came into force on 1 July 2020. I exhibit a copy of those Directions at **JPM3WGO02/206 – INQ000469025**.

491. It is important to note, however, that all management of patients with other long-term conditions were classed as essential services and were therefore required to continue during the relevant period. This is illustrated in the guidance issued by the Essential Services Group within the Welsh Government "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 4 May 2020 and exhibited earlier at **JPM3WGO02/08 - INQ000182443** and updated on 12 June 2020, also exhibited earlier at **JPM3WGO02/16 - INQ000182461**, which were required to be read respectively with Quarters 1 and 2 NHS Wales Operating Framework as exhibited earlier in the statement at **JPM3WGO02/05 - INQ000182468 and JPM3WGO02/10 - INQ000336745**. This guidance outlined that essential services must continue be provided under a general medical services contract but excluding enhanced services (except for the child immunisation scheme, pertussis immunisation for pregnant and rubella for post-natal women and oral anti-coagulation which must continue).

Repeat prescriptions and medication reviews

492. In the letter from Dr Andrew Goodall to Chief Executives of the Local Health Boards dated 11 March 2020 and previously exhibited at **JPM3WGO02/184 – INQ000395690** Dr Goodall outlined that repeat and anticipatory medication is a key area in the pandemic and that patients may be worried about running out of medical they need during the next few weeks, and practices may also want to minimise future demand. Dr Goodall advised that where it is safe and reasonable to do so, suitable patients should have the opportunity to put on a repeat dispensing system but that practices should continue with repeat prescription duration and not increase in order to avoid unnecessary demand and create a challenge within the supply chain.

493. On 17 March 2020, the Deputy Director of the Primary Care Division at Welsh Government, Alex Slade, wrote to all GP practices outlining a number of measures to be taken by general practice to minimise attendance at GP surgeries in order to slow the spread of the virus and to keep the public and healthcare workers safe. One of the measures included requiring GPs and community pharmacies to ensure robust systems were put in place for repeat prescribing which minimise patients attending the practice to order or collect prescriptions. This included maximizing the use of repeat dispensing (batch prescribing) arrangements but did not include extending prescription intervals. It was advised that the duration of repeat authorisation may

need to be considered where it felt safe to do so. I have previously exhibited a copy of the letter at **JPM3WGO02/192 - INQ000468912**.

494. On 20 March 2020, the Welsh Government issued additional advice to GPs seeking support from primary care teams to work together to ensure medicines supply through the appropriate flow of repeat prescriptions between GP practice, community pharmacy and the public. To reduce the footfall in GP practices and community pharmacies the Welsh Government required GPs to: encourage the public to utilise electronic means of prescription re-ordering where possible; utilise current external prescription drop off boxes; allow telephone prescription orders if necessary; ensure community pharmacy delivery drivers/other pharmacy staff to access prescriptions for collection; not fax repeat prescriptions to community pharmacies; not change current prescription intervals; switch all appropriate patients to repeat prescriptions and if that is not possible to issue post-dated prescriptions where appropriate; advise symptomatic patients not to visit community pharmacies; and to communicate changes to services/opening hours to communities pharmacies in the area. I exhibit a copy of that guidance at **JPM3WGO02/208 - INQ000469178**.

495. On 30 March 2020, the Welsh Government issued rapid advice for GP practices and visual quick reference guides for repeat prescriptions and Covid-19. I exhibit a copy of the rapid advice at **JPM3WG02/209 – INQ000469822** and the quick reference guides at **JPM3WG02/210 – INQ000469180** and **JPM3WG02/211 – INQ000469184**. The rapid advice included advice to:

a) Repeat prescription intervals should not be changed (e.g. 28 days) to minimise the risk of supply issues.

b) Consider issuing a repeat dispensing batch up until the next planned medication review or a minimum of 3-6 months.

c) Agree within the practice the duration of repeat dispensing (batch prescriptions) to be issued when the next repeat request is issued, up to a maximum of 13 x 28 days.

d) Discuss with local community pharmacies to ensure a coordinated approach.

e) If needed, discuss with Health Boards options for support to general practices and community pharmacies to ensure robust systems are put in place.

Temporary closure of GP surgeries

496. The responsibility for delivery of general medical services within the NHS in Wales rests with Local Health Boards, including the commissioning of services via a GMS contract, contract management and monitoring and the provision of alternative arrangements where a GP surgery closes (either temporarily or permanently). As such, the Welsh Government was not routinely made aware of any temporary closures of GP surgeries during the relevant period, although the Welsh Government may have been made aware of some branch closures during routine operational discussions with Directors of Primary Care or as part of other engagement and meeting structures during that period.

Prioritising or enabling access to Covid-19 testing for GP practices

497. Throughout the pandemic, the Welsh Government prioritised Covid-19 testing to healthcare staff (including those working in GP practices). This is illustrated in the written statement of Minister for Health and Social Services, Vaughan Gething on 18 March indicating the prioritisation of front-line NHS staff exhibited at **JPM3WGO02/212 - INQ000226951** and a further written statement on 7 April 2020 exhibited at **JPM3WGO02/213 - INQ000182397** which refers to front line NHS staff having been subject to Covid-19 testing since 7 March 2020. The prioritisation of Covid-19 testing for healthcare workers in primary care settings was also referred to in the written statement of the Minister for Health and Social Services, Vaughan Gething, on 15 July 2020 and exhibited at **JPM3WGO02/214 – INQ000227202**.

498. As testing capacity increased to cover the wider population, it was recognised that, given the fundamental role of GPs in the delivery of health and care services, GPs could play a key role in approving access to testing in order to address health inequalities, support the wider access to testing and provide a more joined up service. On 2 December 2020, the Deputy Director for the Primary Care Division of the Welsh Government wrote to the Chair of General Practitioners Committee Wales indicating a scheme which had been rolled out in GP practices in England in which GPs provide Covid-19 PCR testing facilities and set out the Welsh Government's intentions to expand this work into Wales. It was considered that this would: support practices to remain operational by making testing available to symptomatic staff members and their households; streamline patient care; and address health inequality by offering those tests (for those who present with symptoms) to those who are unlikely to get a

test via another route, for example, the elderly and the frail. I have exhibited a copy of the letter at **JPM3WGO02/215 – INQ000118652[50].**

499. The Scheme was subsequently offered to all GPs in Wales from 18 January 2021 on a voluntary, opt in basis. I have exhibited an information sheet which was issued to GP practices on 15 January 2021 at **JPM3WGO02/216 – INQ000469082.** As set out in the information, that service was intended to be a supplementary option for practices and was not intended to replace any of the existing routes to access testing in drive through, walk in and home testing services.

500. Alongside the rollout of PCR testing in GP practices, work was also underway in rolling out Lateral Flow Devices ("LFD") as an alternative means of Covid-19 testing. I exhibit a written statement made by the Minister for Health and Social Services, Vaughan Gething, at **JPM3WGO02/217 - INQ000469061** announcing the rollout 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 had contact with people in those settings. I further exhibit a letter sent from the Chief Medical Officer for Wales to Chief Executives in the NHS dated 7 January 2021 at **JPM3WGO02/218 - INQ000469078** requiring any frontline health or social care professionals visiting a care home to undertake an LFD test before admittance.

501. On 22 February 2021, Alex Slade, the Deputy Director of Primary Care Division sent a letter to all primary care contractors announcing the roll out of twice weekly testing. I exhibit a copy of the letter at **JPM3WGO02/219 - INQ000355944[51].**

Difficulties in conducting remote consultations

502. I have been asked to describe any difficulties in conducting remote consultations due to limitations or deficiencies in existing IT provision in primary care.

503. Whilst much of the technical infrastructure to enable the rollout of the national video consultation service known as "AttendAnywhere" was already in place across GP practices, prior to the rollout the following risks were identified:

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[50] 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 [INQ000469209]

[51] 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 INQ000469091]

a) In the event of a significant usage of the service in the long term, there was a risk that there may not be capacity on the Public Sector Broadband Aggregation service to support the service needs. Whilst the Public Sector Broadband Aggregation network had the physical capacity, it was recognised that the assignment of that capacity to the NHS in Wales may need to increase.

b) Attend Anywhere may not be able to supply all the licences and virtual waiting rooms at pace.

504. In response to the risks that were highlighted, Welsh Government officials worked closely with Public Sector Broadband Aggregation representatives and NHS Wales Informatic Service to increase the capacity of the NHS in Wales internet network connection in parallel with the rollout of the video service. The risk regarding the number of licenses and rooms did not materialise.

505. During the rollout of the AttendAnywhere service, Welsh Government officials were made aware of an alternative video consultation product that had just been released which was an additional module of the 'AccuRX' service. Some GP practices believed that AccuRX Video was more user friendly on account of its integration with one of the GP systems used by roughly half of GPs in Wales. Officials were concerned about having multiple routes for patients to access video consultations during the pandemic as there was a need for clear routes for access. Additionally, there was the potential that additional inclusion, information security, technical infrastructure and technical support burden would have been created in supporting two systems at a time when the wider system was under significant pressure. As a result, the alternative product was discounted, and TEC Cymru was asked to work closely with GP practices that had faced difficulties with the AttendAnywhere system.

Ensuring that changes to service provision and access to primary care services were accessible

506. The rollout of the national video consultation service, AttendAnywhere, took account of those patients who may have additional needs to ensure that those patients could continue to access primary care services and benefit from remote consultation with GPs. Technology Enabled Care Cymru (who led on the rollout of the national video consultation service) worked in partnership with Digital Communities Wales to assist

with the purchase of iPads amongst care home residents. I exhibit a June 2020 press release at **JPM3WGO02/220 – INQ000469008** which confirmed that:

> *"Care homes across Wales are benefiting from digital devices being delivered to them as part of a Welsh Government scheme to help residents keep in touch with friends and family, and to assist with video medical consultations.*
>
> *Over the past few weeks the Digital Communities Wales: Digital Confidence, Health and Well-being Programme, delivered by the Wales Co-operative Centre, has been distributing the devices to care homes in all parts of Wales, and is providing remote support and training to key workers on how to use and operate the technology with people in their care.*
>
> *To date, 745 devices have been delivered to 401 care homes as part of the scheme, with 313 care homes receiving staff training on the NHS Wales Video Consulting Service."*

507. The training undertaken by Technology Enabled Care Cymru on the national video consultation system also included training for those in the community and care home sector to facilitate video consultations.

508. As set out above, the introduction of remote consultations did not completely replace face to face consultations. Where there was a clinical need for a GP to examine a patient face to face (e.g. where it was not possible for the patient to access the national video consultation service) then that facility remained available.

<u>Guidance on how to manage less severe cases of Covid-19 at home</u>

509. The Inquiry has asked me for information on guidance and advice provided to members of the public on how to manage less severe cases of Covid-19 at home. In order to address these questions, I have received support from Sioned Rees (Interim Director Public Health Protection).

510. On 28 January 2020, the Welsh Government published guidance on its website advising anyone who had travelled to Wuhan City in China in the last two weeks and felt unwell to call NHS Direct Wales or 111 for advice. The publication also provided links to Public Health Wales and UK government for further information. I exhibit a copy of the advice note at **JPM3WGO02/221 - INQ000469275**.

511. The Welsh Government published revised guidance on 7 February 2020, and I exhibit the revised guidance at **JPM3WGO02/222** – **INQ000469268**. These amendments required anyone who had returned from Wuhan or Hubei province in the last 14 days to stay indoors and avoid contact with other people, and to phone NHS Direct Wales or 111 irrespective of whether they had symptoms of the virus due to the increased risk from that area. If a person developed a fever, cough or shortness of breath, they were advised to follow the same advice and not to leave home until they had been given advice by a clinician. This guidance also extended the advice to anyone returning from China, Thailand, Japan, Republic of Korea, Hong Kong, Taiwan, Singapore, Malaysia and Macau but only if they developed symptoms of fever cough or shortness of breath.

512. On 7 February 2020, the Welsh Government and Public Health Wales also published bilingual posters which included advice for returning travellers from China or specified countries. I exhibit a copy of the poster at **JPM3WGO02/223 - INQ000468903**.

513. The guidance issued on 7 February 2020 was also supplemented by a statement from the CMO on 21 February 2020 which I exhibit at **JPM3WGO02/224 - INQ000048725**. That statement reaffirmed the advice that all travelers who develop flu-like symptoms within 14 days of returning from mainland China, Thailand, Japan, Republic of Korea, Hong Kong, Taiwan, Singapore, Malaysia or Macau should self-isolate at home immediately and call NHS Direct Wales or 111. That statement also confirmed that people should not go to their GP surgery, local pharmacy or hospital for advice but to phone NHS Direct Wales or 111 for support.

514. The Welsh Government published further revised guidance on 25 February 2020 which I exhibit at **JPM3WGO02/225 - INQ000468909**. These revisions extended the advice to anyone who had returned from Iran, specific lockdown areas in Northern Italy or special care zones in South Korea since 19 February 2020, irrespective of whether a person had symptoms or not, and to Northern Italy (not including Pisa, Florence and Rimini), Vietnam, Cambodia, Laos or Myanmar since 19 February 2020 but only where a person had developed symptoms of fever, cough or shortness of breath. The advice was to stay indoors and avoid contact with other people and to phone NHS Direct Wales or 111.

515. On 28 February 2020, the Minister for Health and Social Services, Vaughan Gething, issued a written statement advising that anyone who had travelled back from an

affected area or who had concerns that they are a close contact of a confirmed case should not attend their GP practice or present at hospital Emergency Departments. I exhibit a copy of the written statement dated 28 February 2020 at **JPM3WGO02/226 - INQ000320747**.

516. On 3 March 2020 a joint action plan between the UK Government and Governments in Wales, Scotland and Northern Ireland entitled "'Coronavirus action plan: a guide to what you can expect" was published which I exhibit at **JPM3WGO02/227 - INQ000057508**[52]**.** The joint plan outlined what the UK had done as a whole to tackle the coronavirus outbreak including the advice provided on managing less severe cases of Covid-19 at home. In an oral statement made in Plenary on 3 March 2020, the Minister for Health and Social Services, Vaughan Gething, referred to the joint plan and that the Welsh Government continued to work closely with the UK Government and the other devolved Governments on coronavirus planning. Within the statement, the Minister reaffirmed the latest advice for returning travellers, and those who may have been in close contact, was available on the Welsh Government advice. I have exhibited a copy of the oral statement made by the Minister at **JPM3WGO02/228 – INQ000321248** at paragraphs 132 to 141.

517. On 6 March 2020, the Welsh Government published revised guidance which I exhibit at **JPM3WGO02/229 - INQ000469152**. This guidance advised any persons returning from Iran, Hubei province in, China, lockdown areas in Northern Italy or special care zones in South Korea in the last 14 days to stay indoors and avoid contact with other people, irrespective of whether they had symptoms or not. The guidance also advised that persons returning from mainland China (outside of Hubei province), Italy (outside of the lockdown areas), South Korea (outside of the special care zones), Cambodia, Hong Kong, Japan, Laos, Macau, Malaysia, Myanmar, Singapore, Taiwan or Thailand should stay indoors and avoid contact with other people if they have a cough, high temperature or shortness of breath. The guidance required that people should not go to a GP surgery, pharmacy or hospital and to call 111 for further advice. The requirement not to attend a GP surgery or A&E was also reaffirmed by the Minister for Health and Social Services, Vaughan Gething, in Plenary on 10 March 2020. I exhibit the oral statement made by the Minister for Health and Social Services at **JPM3WGO02/230 - INQ000469273**.

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[52] 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 [INQ000066061]

518. On 11 March 2020, the World Health Organisation declared that the outbreak of Covid-19 was a pandemic. The Minister for Health and Social Services, Vaughan Gething, issued a written statement on 12 March 2020 announcing a national video consultation service across Wales. This was a web-based service that enabled video consultation between GPs and patients in self-isolation. I exhibit the written statement of 12 March 2020 at **JPM3WGO02/231 - INQ000469153**. On the same day, the UK Government issued advice requiring people to self-isolate at home for 7 days if they develop a high temperature or a new and continuous cough even if those symptoms were mild. The advice also required people not to visit a GP, pharmacy or hospital and to only phone 111 if their symptoms did not improve after 7 days or their symptoms worsened. The advice provided by the UK Government on 12 March was also reflected in a public campaign which was promoted in posters, radio adverts and a television advert featuring Professor Sir Chris Whitty which was shared across the United Kingdom. A key message of the campaign was that the great majority of people will recover well at home. The Welsh Government supported the campaign. A television advert featuring the Chief Medical Officer for Wales, Sir Frank Atherton, conveying the advice on self-isolation at home was broadcast in both English and Welsh from 20 March 2020.

519. At a COBRA meeting on 16 March 2020, it was agreed that for anyone in a household where someone develops a high temperature or a new continuous cough then the whole household should stay at home for 14 days. At a Plenary session on 17 March 2020, the First Minister, Mark Drakeford, updated members of the Senedd on the new advice, and noted that further advice on self-isolation at home was available from Public Health Wales. He also advised people to use the Covid-19 online symptom checker on the NHS Direct Wales if they had concerns about their symptoms. I have exhibited a copy of the transcript from the plenary session on 17 March 2020 at **JPM3WGO02/232 - INQ000469274**.

520. The advice given by Mark Drakeford in Plenary on 17 March 2020 was reflected in a written statement made by the Minister for Health and Social Services, Vaughan Gething, on 18 March 2020 which I have exhibited at **JPM3WGO02/233 – INQ000198641.** This outlined that the individuals displaying symptoms of a new onset continuous cough and/or high temperature were asked to self-isolate at home for 7 days, and that when any member of a household is symptomatic, the other members of the household should stay at home for 14 days. Testing for members of the public

was not routinely recommended at that point in time. This advice was entirely consistent with the advice given by the UK Government and Public Health England.

521. On 19 March 2020, the Welsh Government published "Stay at home: guidance for households with possible coronavirus" reflecting the advice which had been given at Plenary on 17 March 2020. I exhibit a copy of the guidance dated 19 March 2020 at **JPM3WGO02/234 – INQ000469267.**

522. Following 19 March 2020, public guidance on managing Covid-19 at home, including self-isolation periods, how to contact the NHS for advice and when to seek medical attention was issued via updates to the "Stay at home: guidance for households with possible coronavirus" first published on 19 March 2020, albeit that the title of the guidance underwent various changes throughout the relevant period. I have set out below a table showing the dates on which various iterations of the guidance was published using information provided from the National Archives.

Table 16: Table showing the dates on which "Stay at home" guidance was published

Document name	Publication date	Exhibit number
Stay at home: guidance for households with possible coronavirus	9 April 2020	**JPM3WGO02/235 – INQ000469270**
Self-isolation: Stay at home guidance for households with possible coronavirus	22 May 2020	**JPM3WGO02/236 – INQ000469261**
Self-isolation: Stay at home guidance for households with possible coronavirus	28 May 2020	**JPM3WGO02/237 – INQ000469263**
Self-isolation: Stay at home guidance for households with possible coronavirus	26 June 2020	**JPM3WGO02/238 – INQ000469262**
Self-isolation: Stay at home guidance for	2 July 2020	**JPM3WGO02/239 – INQ000469257**

households with possible coronavirus		
Self-isolation: Stay at home guidance for households with possible coronavirus	31 July 2020	**JPM3WGO02/240 – INQ000469264**
Self-isolation: stay at home guidance for households with possible coronavirus	4 August 2020	**JPM3WGO02/241 – INQ000469258**
Self-isolation: stay at home guidance for households with possible coronavirus	26 October 2020	**JPM3WGO02/242 – INQ000469266**
Self-isolation: stay at home guidance for households with possible coronavirus	12 November 2020	**JPM3WGO02/243 – INQ000469259**
Self-isolation: stay at home guidance for households with possible coronavirus	10 December 2020	**JPM3WGO02/244 – INQ000469265**
Self-isolation: stay at home guidance for households with possible coronavirus	21 December 2020	**JPM3WGO02/245 – INQ000469260**
Self-isolation	15 January 2021	**JPM3WGO02/246 – INQ000469246**
Self Isolation	26 April 2021	**JPM3WGO02/247 - INQ000469250**
Self Isolation	7 August 2021	**JPM3WGO02/248 – INQ000469244**
Self Isolation	20 August 2021	**JPM3WGO02/249 – INQ000469249**

Self Isolation	5 October 2021	**JPM3WGO02/250 – INQ000469243**
Self Isolation	15 October 2021	**JPM3WGO02/251 – INQ000469247**
Self isolation	26 October 2021	**JPM3WGO02/252 - INQ000082387**
Self isolation	30 October 2021	**JPM3WGO02/253 - INQ000469252**
Self Isolation	3 December 2021	**JPM3WGO02/254 - INQ000469242**
Self Isolation	7 January 2022	**JPM3WGO02/255 - INQ000469245**
Self Isolation	27 January 2022	**JPM3WGO02/256 - INQ000469251**
Self isolation	18 February 2022	**JPM3WGO02/257 - INQ000469248**
Self Isolation	1 April 2022	**JPM3WGO02/258 - INQ000469253**
Self Isolation	19 April 2022	**JPM3WGO02/259 - INQ000469254**
Self Isolation	17 May 2022	**JPM3WGO02/260 - INQ000469256**
Self Isolation	30 May 2022	**JPM3WGO02/261 - INQ000469255**

523. On 30 June 2022, the guidance referred to above was amended from self-isolation guidance to general guidance which provided advice for people with symptoms of a respiratory infection, including Covid-19. I exhibit a copy of the “Guidance for people with symptoms of a respiratory infection, including Covid-19” dated 2 July 2022 at **JPM3WGO02/262 – INQ000469301**. This provided general advice on managing

symptoms of respiratory infections at home, including taking over the counter medications such as paracetamol to help symptoms and contacting a GP or NHS 111 if symptoms worsen. For those testing positive for Covid-19, the guidance advised people to stay at home and avoid contact with other people for at least 5 days, or 10 days for those who were at higher risk. This was reflective of the Welsh Government's plan for transitioning from pandemic to endemic entitled "Together for a safer future: Wales' long term Covid-19 transition from pandemic to endemic" published on 4 March 2020 and exhibited at **JPM3WGO02/263 – INQ000066072.**

524. Throughout the relevant period, the public messaging on managing Covid-19 within the community was kept under close review and updated regularly in line with the scientific evidence that applied at that time. This is illustrated in a Welsh Health Circular issued by the Chief Medical Officer for Wales on 4 August 2020 previously exhibited at **JPM3WGO02/189 – INQ000048607** in which he outlined concerns that the public message to isolate at home with mild symptoms may have encouraged people to attempt to cope alone for too long without contacting 111 or their GP. As a result, public messaging was adjusted to encourage people not to attempt to cope on their own with anything more than short lived, mild symptoms and to contact 111 or a GP if symptoms do not improve after 7 days, or if a person was experiencing vomiting, breathlessness, or fatigue preventing normal daily activities. The Community Covid-19 Framework exhibited earlier in the statement, which provides support for primary care practitioners in decision making regarding the management of patients presenting with suspected or actual Covid-19, was also updated accordingly.

Ante-natal care, maternity services, postpartum and neonatal care

525. The Inquiry has asked me for information about ante-natal care, maternity services, postpartum and neonatal care. In order to address these questions, I have received support from Professor Chris Jones, Deputy Chief Medical Officer for Wales.

Steps taken by the Welsh Government to enable ante-natal care, maternity services and postpartum care to be delivered safely during the relevant period

526. Prior to the pandemic, the Welsh Government had in place its Strategic Vision for Maternity Services in Wales which set out the actions identified to improve outcomes in the provision of safe and effective maternity services (including antenatal, intrapartum and postnatal care). I exhibit a copy of the Welsh Strategic Vision, which

was co-produced with key stakeholders, at **JPM3WGO02/264 - INQ000353471.** Although this Strategic Vision did not specifically cover pandemic preparedness, it served two important functions in this context. Firstly, it set expectations for service delivery including a commitment that women would receive ante and postnatal continuity of care by no more than two midwives and two obstetric teams and, secondly, it ensured that the seven Local Health Boards and other key stakeholders worked together with the Welsh Government in key forums to deliver a coordinated response to the pandemic.

527. As set out earlier in this statement, on 13 March 2020, the Minister for Health and Social Services issued a framework of actions which I exhibited earlier at **JPM3WGO02/58 - INQ000320755** which enabled Local Health Boards to pause some routine activities in order to prepare for an increase in Covid-19 demand by allowing services and bed to be reallocated and for staff to be redeployed and retrained in priority areas. On the same day, Welsh Government officials met with maternity teams from the NHS during which it was identified that maternity services and antenatal care would need to continue in accordance with NICE guidelines and that a national coordination and guidance was required to ensure that services were delivered safely and consistently across Wales. This was however with the exception of in person ante-natal classes which were suspended. I exhibit a note from the meeting dated 13 March 2020 at **JPM3WGO02/265 - INQ000469847.**

528. The requirement for continuing to deliver urgent surgery including access to urgent diagnostics and related rehabilitation was also set out guidance issued by the Essential Services Group within the Welsh Government "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 4 May 2020 and exhibited earlier at **JPM3WGO02/08 - INQ000182443** and updated on 12 June 2020, also exhibited earlier at **JPM3WGO02/16 - INQ000182461**, which were required to be read respectively with Quarters 1 and 2 NHS Wales Operating Framework as exhibited earlier in the statement. These set out that maternity services including antenatal screening, neonatal services including transport and mental health crisis services including perinatal care must continue. It was also identified that access to maternity services for antenatal, intrapartum and postnatal care would include provision of community services on a risk assessed basis and that care would be underpinned by Royal College of Obstetricians and Gynaecologists guidance. The reference to "risk assessed basis" was a reference to the assessment guidance provided by the Royal

College of Midwives and the Royal College of Obstetricians and Gynaecologists which Local Health Boards were required to follow. I exhibit a copy of that guidance at **JPM3WGO02/265a – INQ000176666[53].**

529. In addition to the above frameworks and essential services guidance, there was also specific guidance on maintaining neonatal services and maintaining maternity services issued throughout the relevant period. These were both developed by the Wales Maternity and Neonatal network in conjunction with the Welsh Government's Essential Services group. The Wales Maternity and Neonatal Network is a clinical network forming part of the NHS Wales Health Collaborative established in 2019 whose focus is to bring together stakeholders across Wales to support each other in improving the overall safety and quality of maternity and neonatal services and experiences of families in Wales. These guidance documents are described further below.

530. I have exhibited a copy of a letter from the then Chief Executive of NHS Wales, Dr Andrew Goodall, dated 21 April 2020 to the Local Health Boards and the Welsh Ambulance Services NHS Trust requiring that they implement the requirements of "Maintenance of Essential Neonatal Service through the Covid-19 pandemic" with immediate effect. I exhibit a copy of the letter at **JPM3WGO02/266 - INQ000227101** and a copy of the guidance at **JPM3WGO02/267 - INQ000468968**. The guidance required the following actions to be taken:

   a) A requirement on the Wales Maternity and Neonatal Network, Local Health Boards and the Welsh Ambulance Services NHS Trust to work together to determine a pathway to ensure women who present in early labour are appropriately transferred to a Maternity Unit aligned to a Neonatal Intensive Care Unit.

   b) A requirement on Welsh Ambulance Services NHS Trust to develop a transport continuity plan to ensure the neonatal transport service is maintained.

   c) A requirement on Local Health Boards to complete workforce plans that identify the staffing requirements to maintain neonatal services and the actions

[53] 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 [INQ000484922]

required to continue to provide safe services at stages levels of a depleted workforce.

d) To continue essential neonatal outpatient activity.

e) Having a regional/national understanding of cot closures due to infection purposes.

f) Maintaining postnatal monitoring of mother and baby and new-born screening.

531. I have also exhibited "Maintenance of Essential Maternity Service through the Covid-19 pandemic" at **JPM3WGO02/268 - INQ000469882.** The guidance required the following actions to be taken:

a) A requirement on Local Health Boards to complete workforce plans that identify the staffing requirements to maintain maternity services and the actions required to continue to provide safe services at staged levels of a depleted workforce.

b) A requirement on Local Health Boards to develop a plan for delivering antenatal care which is individualised to meet the needs of the woman, including perinatal mental health assessments and meeting obstetric/fetal medicine ultrasound and screening obligations.

c) A requirement on Local Health Boards to have in place necessary provisions and plans for unscheduled maternity care, including the availability of appropriate environments of care Covid-19/non-Covid-19 areas and include appropriate escalation procedures for women who display symptoms following admission and for those deteriorating patients who require admission to intensive care settings.

d) The provision of midwifery led intrapartum care outside of the obstetric unit.

e) A requirement on Local Health Boards to monitor and report all in-utero transfers on a weekly basis to the Wales Maternity and Neonatal Network. It is my understanding that "in utero transfers" refer to transportation of a woman whilst still pregnant to ensure that the baby and/or woman is in the most appropriate place to receive care during and after birth.

f) A requirement on all Local Health Boards to develop a plan for delivering postnatal care for women and babies, including infant feeding, perinatal mental health and bereavement support/care.

g) A requirement to continue staff training and governance.

532. Whilst it was recognised that Local Health Boards were fundamentally responsible for ensuring that it was delivering safe ante-natal care, maternity services and postpartum care during the relevant period, and that they were expected to document all risks on their risk register and escalate internally as appropriate, the Welsh Government also took the following steps to ensure that antenatal care, maternity services and postpartum care continued to be safely delivered during the relevant period:

a) Publishing a risk analysis document developed by Maternity and Neonatal Network and agreed at a meeting of the Maternity and Neonatal Covid-19 Group on 25 March 2020 to be used by Local Health Boards in assessing the impact of the pandemic on their respective services and to take mitigating actions. Areas assessed as "red" were subsequently discussed at a weekly Maternity and Neonatal Clinical Forum (further on that is provided below). I exhibit a copy of the risk analysis document at **JPM3WGO02/269 - INQ000469288.** This includes ensuring that all staff had received adequate training on Covid-19 responses, triage procedures and infection control procedures.

b) Ring fencing maternity and obstetric staff which meant that they could not be deployed into other healthcare areas and requiring staff who had been previously deployed elsewhere in the health system to be returned to maternity services.

c) The Wales Maternity and Neonatal Network, on behalf of the Welsh Government, hosted a virtual Maternity and Neonatal Clinical Forum on a weekly basis, which brought together senior maternity leaders from Local Health Boards to share information and learning from mothers and babies in their care, and raise any issues of concern. The Wales Maternity and Neonatal Network played a key role in coordinating the assurance process across Wales

and, following discussion, would escalate any concerns or issues to the Essential Services Cell of the Welsh Government.

d) Working with Public Health Wales to purchase the Solihull Package an online antenatal course, made available as a resource to all Local Health Boards at a time when in-person ante-natal classes were not taking place.

e) Working with Marian Knight at the UK Obstetrics Surveillance System and with Local Health Boards to ensure Covid-19 maternity information and data was correctly collated and reported to ensure a national understanding of the impact of the pandemic for pregnant and new mothers and for their babies. Subsequently discussed UK Obstetrics Surveillance System findings at Maternity and Neonatal Network weekly clinical forum meetings.

f) Through the weekly Maternity and Neonatal Network Clinical Forum meetings, weekly meetings ensuring Local Health Board teams understood the responsibility to check the Royal College of Obstetricians and Gynecologists and Royal College of Midwives' websites for any additional updates to guidance.

g) Requiring that all Local Health Boards in Wales continued to be staffed to Birthrate plus standards which is a nationally recognised assessment model for midwifery staffing. As a result of workforce issues which arose during the relevant period, the Welsh Government commissioned Birthrate plus (a tool recommended by NICE for safe staffing within maternity services) to undertake a review of the number of midwives required to meet future needs of families and to fulfil the policy direction in Wales as contained in the Five Year Maternity Vision.

The impact of the pandemic on ante-natal and maternity care

533. I have been asked to provide information held by the Welsh Government regarding the impact of the Covid-19 pandemic on the delivery of ante-natal and maternity care in Wales during the relevant period. I do so below, in respect of the following areas:

On the ability to maintain ante-natal care such as screening, scans and other appointments

534. The Welsh Government's policy was that ante-natal care such as screening, scans and other appointments must continue to be provided throughout the relevant period

in accordance with NICE guidelines, with the exception of in person ante-natal classes.

535. As set out above, the Wales Maternity and Neonatal Network, on behalf of the Welsh Government hosted a virtual maternity and neonatal clinical forum on a weekly basis which was attended by clinical leads from every Local Health Board and during which issues of concern could be raised. These meetings served to inform Welsh Government officials of service "pinch points" and where they may be a need for national intervention. I am not aware that any national intervention was ever required in relation to maintaining ante-natal care and, whilst there were workforce pressures (see further on that below), antenatal care (with the exception of in person ante-natal classes) continued during the relevant period. This is illustrated in the statistics held by the Welsh Government which suggests an increase in women receiving initial ante-natal assessments within the recommended 10-week timeframe as compared with the figures prior to the pandemic:

Table 17: Percentage of women receiving initial ante-natal assessments within the recommended 10-week timeframe between 2018 - 2022

No Women having initial assessment by 10 weeks	
2018	73%
2019	72%
2020	76%
2021	81%
2022	77%

536. I have exhibited the source of these statistics for 2018 at **JPM3WGO02/270 – INQ000469309**, 2019 at **JPM3WGO02/271 - INQ000469310**, 2020 at **JPM3WGO02/272 - INQ000469306**, 2021 at **JPM3WGO02/273 - INQ000469307** and 2022 at **JPM3WGO02/274 – INQ000469308**.

On the use of online/remote access to maternity care and services

537. As set out above, the Welsh Government funded the introduction of "Attend Anywhere". This was very helpful in maintaining outpatients services, particularly in

ante-natal care, because it enabled virtual consultations such as booking appointments and non-clinical care to be undertaken virtually. From the beginning of the pandemic, midwives with underlying health conditions were deployed to providing telephone and online support utilising this consultation system and played a key role in maintaining maternity care and services by maximising the skills within the workforce.

On the availability of midwives, specialist obstetricians and other maternity staff

538. In requiring the continuation of ante-natal and maternity care across Wales, it was clearly important that there existed the appropriate numbers of midwives, specialised obstetricians and other maternity staff to continue to deliver those services. Accordingly, the Welsh Government took a number of steps to ensure the availability of such staff such as: ring-fencing maternity and obstetric staff so that they could not be deployed elsewhere in the health system; requiring staff who had been previously deployed in the health system to be returned to maternity services; encouraging former midwives to join the temporary register and assist with service provision; regularly meeting with the Nursing and Midwifery Council, the Royal College of Midwives and all Local Health Boards to discuss staffing levels, skill mix and maternity workforce; and working with Health Education and Improvement Wales to commission student numbers to calculate forward projections of planned midwifery vacancies.

539. However, notwithstanding these steps taken by the Welsh Government, there remained workforce pressures due to sickness (increasingly Covid-19 related), shielding and Covid-19 isolation. Some Local Health Boards reported amalgamated absence rates in excess of 30% which put pressure on the delivery of services, with vacancies at their highest in the summer months prior to the annual intake of newly qualified staff starting. At times this required centralisation of services to ensure safe delivery of care. The Minister for Health and Social Services was regularly informed of staffing issues in several Local Health Boards which experienced significant absences during the relevant period. I have set out below examples of such instances in staff shortages and resulting reduction in maternity service provision.

    a) I exhibit a ministerial briefing at **JPM3WGO02/275 - INQ000469302.** This briefing set out that, on 17 December 2020, the Chief Executive of Aneurin Bevan University Health Board wrote to Dr Andrew Goodall to inform him they had taken the decision to temporarily close the midwifery led units at Nevill Hall

Hospital and Royal Gwent Hospital due to the high number of midwives who were unable to work due to illness/isolation. Units were closed until 4 January 2021, and women receiving midwifery led care were instead seen at either Ysbyty Yatrad Fawr or at the Grange Hospital. Women in receipt of consultant led care continued to be seen at the Grange Hospital.

b) I exhibit a ministerial briefing dated 23 December 2020 at **JPM3WGO02/276 – INQ000469063.** This briefing sets out that Swansea Bay University Health Board reported that their maternity services had been significantly affected by both Covid-19 and non-Covid-19 staff absences in both the community and hospital. As a result, they had taken a decision to suspend the homebirth service to the inability to safely cover the intrapartum on-calls.

c) I exhibit a ministerial briefing at **JPM3WGO02/277 - INQ000469289**. This briefing sets out that, in July 2021, the Welsh Government were made aware of staffing shortages in Swansea Bay maternity services which required a cessation of homebirth services to enable centralisation of staffing resource.

d) I exhibit a ministerial briefing at **JPM3WGO02/278 - INQ000469304.** This briefing set out that on 7 October 2021 the Welsh Government were advised of the suspension of a home birthing service and the temporary closure of all the Midwifery-Led Units at Aneurin Bevan University Health Boards to enable the centralisation of birthing services at the Grange University Hospital with temporary redeployment of midwives.

540. The Welsh Government was informed of changes to services offered through both informal and formal routes and in exceptional circumstances where the closure of the unit/service was anticipated to be for a considerable time or where there was media interest, an informal briefing was provided to the Minister. Where a service was paused for a very short time (e.g. overnight or on a specific shift where sickness/shielding rates were high) and the Welsh Government was aware of the cessation through an informal route, no briefing was sent to the Minister.

541. At the start of the pandemic, the Tirion Birth Centre in Cwm Taf University Health Board was also closed but this was due to a need to move midwifery staff to other units as part of the Local Health Board's Covid-19 response. This was a standalone birth centre in Royal Glamorgan Hospital. When closed, women who would have

chosen it as their preferred place of birth would have been offered to go to Prince Charles Hospital instead where an alongside midwifery unit was available as well as the obstetric led unit. I exhibit emails at **JPM3WGO02/279 - INQ000469031** which confirm that the Tirion Birth Centre was reopened again from 5 October 2020.

542. In attempting to mitigate the pressures caused by workforce pressures and absences, the Welsh Government did consider deploying third year midwifery students. However, the Welsh Government ultimately decided not to do so to ensure that the students continued with the placements in maternity, where they would gain the specific relevant maternity based clinical experience to allow them to qualify in the Autumn of 2020 and so there was not an added pressure on midwifery vacancies at such a crucial time. Wales committed at the outset of the pandemic to ensuring that any emergency measures would not unduly affect students' ability to complete their training and register at the time originally scheduled for. Welsh Government worked with partners across the NHS and higher education, with Health Education and Improvement Wales, the Nursing and Midwifery Council and the Royal Colleges to successfully implement the Nursing and Midwifery Council emergency education standards. The standards were designed to allow greater flexibility in the delivery of nursing and midwifery programs. Universities, placement providers, and all key stakeholders revised arrangements to enable students (subject to individual risk assessment), to continue placement learning opportunities and work towards the timely completion of programme requirements notwithstanding the continuing impact of pandemic conditions throughout the pandemic. If third year midwifery students had been deployed to general nursing roles, they would not have received the maternity -specific clinical experience which would allow them to qualify in the pre pandemic timeframes. Throughout the relevant period, the Welsh Government was highly conscious not to compromise the training of maternity staff, and particular students.

On the availability of resources, including clinicians, for caesarean deliveries

543. The Welsh Government's policy was that caesarean deliveries must continue to be maintained throughout the relevant period.

544. I am not aware that any national intervention was ever required in relation to the availability of resources, including clinicians, for caesarean deliveries and, whilst there were workforce pressures, caesarean deliveries continued during the relevant period. This is illustrated in the statistics published by the Welsh Government

(through Stats Wales) which suggests an increase in women having caesarean deliveries as compared with the figures pre-pandemic:

Table 18: Percentage of women having caesarean deliveries between 2018 and 2022

Year	Total Caesareans
2018	28%
2019	29%
2020	29%
2021	31%
2022	35%

The impact of infection control measures in hospitals, including any effects on healthcare-associated infection rates from the introduction or withdrawal of visitor restrictions

545. The Welsh Government does not hold data on the impact of infection control measures in hospitals, including any effects on healthcare-associated infection rates from the introduction or withdrawal of visitor restrictions. Such information would be held by individual Local Health Boards. No specific issues were raised in the weekly Maternity and Neonatal Network Clinical Forum meetings.

Whether restrictions on visitors, or on other restrictions, impacted on women's right to have a birthing partner attend antenatal appointments or during labour

546. Throughout the relevant period, a mother was able to have a birthing partner attend the delivery unit through active labour but that restrictions outside of active labour were considered necessary for the prevention and control of infection in healthcare settings so as to ensure the health safety and wellbeing of women, families and staff supporting them. The Welsh Government did however receive a considerable amount of correspondence expressing frustration at the rules. Ministers were very aware of the volume of letters received at the time as a proportion of letters came directly from other MSs or MPs. The responses encouraged the correspondent to speak to their midwife about their concerns and provided information that Local

Health Boards were expected to allow support assistants (who could have been a family member) if they had any additional needs.

547. The Community Health Councils published a report on maternity care which outlines women and their families' experiences of the restrictions on visiting. I exhibit a copy of the report at **JPM3WGO02/280 - INQ000412570.**

On the management of miscarriages and ectopic pregnancies

548. The Welsh Government's policy was that care for the management of miscarriages and ectopic pregnancies must continue to be maintained throughout the relevant period. I am not aware that any national intervention was ever required in relation to the management of miscarriages and ectopic pregnancies and, whilst there were workforce pressures, such services continued during the relevant period.

On the availability of home-births

549. The Welsh Government was aware that, at the outset of the pandemic, there had been a rise in home births as mothers were scared to go into hospital due to concerns of contracting Covid-19. The Chief Nursing Officer for Wales's office issued public messaging to dissuade mothers from home births and worked with the Welsh Ambulance Service Trust on that. I exhibit a copy of the minutes of the Nurse Director meeting dated 31 March 2020 as exhibited at **JPM3WGO02/281 - INQ000412476**. Home and free birth messaging was clear that postnatal care was still in place.

550. However, as set out above, the Welsh Government were made aware of instances where Local Health Boards chose to centralise services and suspend home births due to staff shortages.

The availability of birthing pools, pain relief and anaesthetics

551. The Welsh Government does not hold any information on the availability of birthing pools, pain relief and anaesthetics and no specific issues were raised on such matters during the weekly Maternity and Neonatal Network Clinical Forum meetings. Such information would be held by Local Health Boards.

On timely access to emergency services for maternity care, including ambulances, 999 or 111

552. The Welsh Government recognised that Covid-19 was a threat to the resources of the Wales Ambulance Service Trust, and that this may lead to delays in the system

and responding to emergencies. Accordingly, to help support decision making and mitigate the risk of any detrimental impact, the Wales Maternity and Neonatal Network published the All Wales Criteria for Selecting Mode of Transport for Women and/or Babies Requiring Transfer from Free-Standing Midwifery Units or Homebirth during Covid-19 pandemic which I have exhibited at **JPM3WGO02/282 – INQ000468963.**

On the nature and number of healthcare staff present in delivery suites

553. The Welsh Government does not hold any information on the nature and number of healthcare staff present in delivery suites and no specific issues were raised on such matters during the weekly Maternity and Neonatal Network Clinical Forum meetings. Such information would be held by Local Health Boards.

On the average length of postnatal hospital stay

554. The Welsh Government does not hold any information on the average length of postnatal hospital stay and no specific issues were raised on such matters during the weekly Maternity and Neonatal Network Clinical Forum meetings. Such information would be held by Local Health Boards.

Guidance for ante-natal and obstetric care

555. Aside from the "Maintenance of Essential Neonatal Service through the Covid-19 pandemic" and "Maintenance of Essential Maternity Service through the Covid-19 pandemic" which were developed by the Welsh Maternity and Neonatal network, in conjunction with the Welsh Government's Essential Services group, the Welsh Government did not publish any clinical guidance for ante-natal or obstetric care during the relevant period. There were no changes to the schedule of screening, scans and appointments, or the frequency of universal care points or changes to standards and therefore all such matters continued in accordance with NICE guidelines established before the pandemic.

556. There were however a number of Maternity Covid-19 related notices, professional standards and guidance issued, including guidance by professional colleges and bodies including Royal College of Midwives and Royal College of Obstetricians and Gynecologists, British Association of Perinatal Medicine, Royal College of Pediatrics and Child Health and NICE. The guidance was constantly evolving throughout the pandemic as more was understood and risks assessed and was reviewed almost

daily to include the most up to date research and clinical evidence. Local Health Boards were aware to ensure this guidance was understood and followed by clinical staff. Discussion of changes would take place at weekly sitrep. The Royal College of Midwives also produced several infographics for staff and families based on Royal College of Midwives/Royal College of Obstetricians and Gynecologists Covid-19 guidance four of which were translated into Welsh. The Welsh Government was not involved in the development of any this guidance.

Guidance or advice for pregnant women

557. I am not aware of any advice given to pregnant women that was published by the Welsh Government during the relevant period, other than that which was given to pregnant women regarding the Covid-19 vaccination. Advice regarding shielding when pregnant and pregnant worker guidance was issued by the Royal College of Obstetricians and Gynecologists and the UK Government.

558. On 24 February 2021, Public Health Wales issued guidance regarding the vaccination to certain groups within the pregnant population. I exhibit a copy of the guidance at **JPM3WGO02/283 - INQ000401541**[54] which was developed in collaboration with Joint Committee on Vaccination and Immunisation, Royal College of Midwives and Royal College of Obstetricians and Gynecologists. This was a resource designed to help women to make an informed choice about whether to get the Covid-19 vaccine if they are pregnant or trying to conceive. It included information on the benefits and risks of the vaccination, what was known about the effects of the vaccination in pregnant women as well as more general information about the vaccine. On 6 April 2021, the Joint Committee on Vaccination and Immunisation issued guidance recommending that all pregnant women receive the vaccine in view of the latest scientific findings.

559. Whilst the Welsh Government was not involved in the development of this guidance, the Welsh Government did take steps to encourage pregnant women to take up the vaccinations.

560. On 1 October 2021, the Chief Nursing Officer for Wales and the Deputy Chief Medical Officer for Wales issued a letter to the NHS asking healthcare professionals to proactively encourage pregnant mothers to get vaccinated against Covid-19 in view

[54] 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 [INQ000469876]

of the data from the UK Obstetric Surveillance Services which showed that numbers of hospital admissions with Covid-19 in pregnant mothers were increasing week-on-week. I exhibit a copy of the letter at **JPMWGO02/284 – INQ000469135.** The letter also required all Local Health Boards to support all GPs, practice nurses, midwives, Health Visitors and obstetricians to advise pregnant mothers on vaccination in pregnancy at every antenatal contract and ensure information and materials are available for pregnant mothers in all antenatal and primary care settings and encouraged all maternity staff to be vaccinated.

561. On 17 December 2021, the Chief Nursing Officer for Wales, the Deputy Chief Medical Officer (Vaccines) and the Senior Medical Officer issued a further letter asking Local Health Boards to provide current up to date information regarding vaccinations in pregnant women and to further encourage uptake amongst the pregnant population in view of low take up. I exhibit a copy of the letter at **JPM3WGO02/285 - INQ000270385**[55].

Reluctance or delay amongst pregnant women to seek ante-natal or maternity care

562. I am aware that there was some anecdotal evidence conveyed at the outset of the pandemic regarding reluctant amongst pregnant women to attend hospital-based appointments or to admit community midwives. The Nursing Directorate worked with Local Health Boards to look at ways in which the service could instill confidence in new mothers to access support. For example, this involved having the same midwife or health visitor undertaking 10-day weight checks to avoid concern about risk of infection. Notwithstanding such anecdotal evidence, however, this did not appear to impact upon the number of women actually attending their appointments – as is evidenced by the increase in initial assessments having been undertaken within the recommended 10-week time frame as set out above.

563. As set out earlier, the Welsh Government was aware that, at the outset of the pandemic, there had been a rise in home births as mothers were scared to go into hospital due to concerns of contracting Covid-19. The Chief Nursing Officer for Wales' office issued public messaging to dissuade mothers from home births and worked with the Welsh Ambulance Service Trust on that. I exhibit a copy of the minutes of the Nurse Director meeting dated 31 March 2020 at **JPM3WGO02/281 -**

[55] 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 [INQ000469138]

INQ000412476. Home and free birth messaging was clear that postnatal care was still in place.

564. I am also aware that there were reports of some mothers choosing to "free birth" (birthing on their own without midwifery assistance) out of fear of attending hospital due to the risk of contracting Covid-19, as indicated in the minutes of the meeting of the Health and Social Service Group's Quality and Delivery Board on 16 September 2021 at **JPM3WGO02/286 - INQ000469303**.

565. In order to improve public confidence in maternity services, the Welsh Government issued various public statements including a BBC press statement made on 1 April 2020 and a recorded message from the Chief Nursing Officer for Wales on the Welsh Government's social media channels. I exhibit the transcript from the Chief Nursing Officer for Wales' message at **JPM3WGO02/287 – INQ000469189.** Specifically for maternity services, in which the message was that the service was open for business, and it was really important that women continue to attend scheduled routine care when they are well.

566. Whilst the Welsh Government was aware that there was a variation in the vaccine take up in pregnant women according to socioeconomic and ethnic background (as set out in exhibit **JPM3WGO02/285 - INQ000270385** which I exhibited earlier in this statement), the Welsh Government does not hold any data to indicate any variation between different ethnic or age groups or geographical area regarding a reluctance or delay amongst pregnant women to access maternity services.

Impact of the pandemic on the delivery of neonatal care

567. The Welsh Government's policy required neonatal care to continue during the relevant period. Notwithstanding that, concerns around staffing levels (due to sickness or caring responsibilities) in neonatal units were regularly reported by Local Health Boards to the Welsh Government. Accordingly, capacity was at times very stretched, but I am not aware of any instances of a failure to deliver neonatal care at any point during the relevant period.

Screening, care and treatment for lower gastrointestinal ('lower GI') cancer

568. The Inquiry has asked me for information about screening, care and treatment for lower gastrointestinal ("lower GI") cancer. In order to address these questions, I have

received support from Professor Chris Jones (Deputy Chief Medical Officer for Wales).

Steps taken to enable screening, care and treatment for lower GI cancer to be maintained during the pandemic

569. As set out earlier in this statement, on 13 March 2020, the Minister for Health and Social Services, Vaughan Gething, issued a written statement about health bodies pausing some routine activities in order to prepare for an increase in Covid-19 demand – exhibited earlier at **JPM3WGO02/58 - INQ000320755.** However, the Minister was clear in his statement that access to cancer treatment would be maintained, and as such services for the care and treatment of cancers were required to continue. This applied in respect of all types of cancers (including lower GI cancer). This reflected the Welsh Government's general policy approach to cancer services, including the strategic policy in place for the delivery of cancer services that was in place prior to the pandemic, which we believe is a more fair and equitable approach and reflects the common challenges across different types of cancers.

570. The requirement for continuing to deliver urgent cancer treatments, including access to urgent diagnostics and related rehabilitation was also set out guidance issued by the Essential Services Group within the Welsh Government "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 4 May 2020 and exhibited earlier at **JPM3WGO02/08 - INQ000182443** and updated on 12 June 2020, also exhibited earlier at **JPM3WGO02/16 - INQ000182461**, which were required to be read respectively with Quarters 1 and 2 NHS Wales Operating Framework as exhibited earlier in the statement.

571. These guidance documents also referred to and endorsed the use of "Cancer Services in Wales during Covid-19" which was published by the Wales Cancer Network on 7 April 2020 and exhibited at **JPM3WGO02/288 - INQ000399069.** The Wales Cancer Network is responsible for bringing NHS organisations together to collaborate on the development and delivery of cancer services and to provide expert services on cancer services to the Welsh Government. It aims to improve cancer patients' outcomes and enhance patient experience but, like the Welsh Government, has no role in the commissioning or provision of cancer care. During the relevant

period, the Wales Cancer Network formed part of the NHS Collaborative but since 2023 has been part of the NHS Executive for Wales.

572. As set out in "Cancer Services in Wales during Covid-19", the cancer services which were required to continue were: emergency care; investigation of patients who have signs or symptoms that have a high chance of being cancer; urgent surgery (where disease progression leading to emergency or incurability within four weeks is likely); radiotherapy (definitive treatment of rapidly growing cancers); and chemotherapy (curative treatment of acute leukaemia and other haematological malignancies, testicular cancer). Other cancer treatments were required to be delivered according to the risk of treatment and the availability of care to manage associated toxicities. Accordingly, whether services for the care and treatment for lower GI cancer were maintained, depended upon a patient's circumstances and their clinical needs. This guidance also provided a framework describing prioritised categories of interventions which I have set out in further detail below.

573. However, some non-urgent services for lower GI cancer were paused completely. On 22 March 2020, the British Society of Gastroenterology advised that gastro-intestinal endoscopy procedures are aerosol generating, irrespective of the Covid-19 status of the patient, because the virus can be shed before any symptoms are present. In view of that, and in order to reduce the requirement for PPE and FFP3 masks to the absolute essential treatments and services, the British Society of Gastroenterology advised that all routine and non-urgent GIE procedures should stop immediately. I have exhibited a copy of the advice of the British Society of Gastroenterology and its covering email dated 22 March 2020 at **JPM3WGO02/289 - INQ000468918** and the associated advice document, Executive Summary UK wide Endoscopy Services COVID-19 **- JPM3WGO02/290 - INQ000453785**. This led to a significant reduction in gastrointestinal endoscopy in the early pandemic before the guidance was relaxed and non-urgent endoscopy recommenced.

574. On 20 March 2020, the Welsh Government announced that the population screening for bowel cancer ("Bowel Screening Wales") operated by Public Health Wales was to be temporarily paused and I exhibit a copy of the press release at **JPM3WGO02/291 - INQ000468917.** The British Society of Gastroenterology also advised that bowel cancer screening should stop immediately in view of the evidence which suggested that Covid-19 was present in secretions, saliva and diarrhoeal stools. This is reflected in their advice of 22 March 2020 which is exhibited above.

575. The continuation of essential services, and the pausing of non-urgent services, was consistent with the Welsh Government's guidance which was in place prior to the pandemic on critical care escalation management of large unplanned increase in demand as exhibited earlier at **JPM3WGO02/32b – INQ000469291**[56].

576. In addition to requiring NHS health bodies in Wales to continue to provide essential services such as urgent cancer services via frameworks and guidance as set out above, the Welsh Government also took additional actions to support the continuation of urgent cancer services during the relevant period. Again, such actions were not aimed towards any specific types of cancer, but instead applied to services for all types of cancer including lower GI cancer.

577. On 27 March 2020, Welsh Government officials met with representatives from the NHS to discuss continuity of cancer care and treatment. I attach a copy of the note from the meeting at **JPM3WGO02/293 - INQ000469154**. It was acknowledged at that meeting that there had been disruptions to cancer services and that there was a need to develop a consistent, transparent and equitable approach in terms of access to diagnostic tests and treatment in order to minimise harm. It was agreed that an All-Wales approach was needed to maintain services, and that there was a need to consider how the private sector could assist in maintaining services. It was also recognised that the Wales Cancer Network could play a key role in developing possible solutions for delivering the capacity to meet demand.

578. Dr Andrew Goodall, who was at that time the Chief Executive of the NHS in Wales, sent the following letters to the NHS on the continuation of cancer services:

    a) A letter of 1 April 2020 requesting that: urgent consideration be given to how to ensure emergency and urgent cancer treatment could continue; appropriate records be kept where referrals or treatment plans departed from normal practice; and regional solutions be agreed to ensure urgent needs could be met, including the possible use of the independent healthcare sector. I exhibit a copy of the letter of 1 April 2020 at **JPM3WGO02/294 - INQ000227390.**

[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 [INQ000469298]

b) A letter of 9 April 2020 introducing the "Cancer Services in Wales during Covid-19" which provided advice on what services must be maintained as referred to earlier in this statement. I exhibit a copy of the letter of 9 April 2020 at **JPM3WGO02/295 - INQ000262353**[57]**.** In this letter, Dr Andrew Goodall requested that health bodies ensured that their services aligned with that guidance and that if that could not be achieved locally that he expected health bodies to work together to find regional or cross organisational solutions, maximizing use of independent hospitals and cancer centres.

c) A letter of 5 May 2020 in which Dr Andrew Goodall highlighted his concerns about cancer services and the need to urgent review the extent of the impact of the pandemic on cancer treatments. I exhibit a copy of the letter of 5 May 2020 at **JPM3WGO02/296 - INQ000227155** (incorrectly dated 5 April 2020). In that letter Dr Goodall asked for an update on the eight requested actions in the guidance sent with the letter of 9 April 2020 and noted that he had asked the Wales Cancer Network to work with Local Health Boards and NHS Trusts to advise on local plans and the need for any regional or national solutions.

579. 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 and including observers from the Welsh Government was convened to track patient pathway data and service pressures.

580. The Welsh Government was also instrumental in ensuring that any cancer services which had been paused or reduced during the relevant period were reinstated as quickly as possible. This is illustrated in the Operating Frameworks exhibited earlier in this statement, which encouraged a safe return to routine services.

581. To support the reinstatement of cancer services, the Wales Cancer Network also published "A Framework for the Reinstatement of Cancer Services in Wales during Covid-19" in June 2020 and which was endorsed by the Welsh Government. I

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[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 [INQ000227100]

previously exhibited a copy of that framework at **JPM3WGO02/14 - INQ000353461.** This guidance provided recommendations on how to continue to deliver cancer care in a Covid-19 context, to restart certain activity such as complex surgery, and how to protect patients waiting or soon to be receiving treatment. It recommended that healthcare services should:

a) Have clear plans and processes for delivering cancer investigations and treatments in an appropriately Covid-19 protected environment. These should separate staff working in acute and elective services and vulnerable patients attending for elective care from attending acute care services. My understanding is that the reference to "acute" within the Framework would include urgent or emergency services.

b) Recommence complex surgery and deal with the growing backlog of deferred cases. These plans must consider the needs of the regional and national, as well as the local resident populations.

c) Work together and with supportive national groups to share capacity and demand modelling for diagnostic and treatment cancer services.

d) Share activity information by service type and categories of patients stratified by risk and benefit of intervention. My understanding is that this meant Local Health Boards sharing their data at the regional and national level so that neighbouring Local Health Boards and national teams such as the Wales Cancer Network could support system collaboration and decision making.

e) Have robust safety netting processes in place. Lists of patients who have been deferred from immediate treatment must be carefully maintained (and shared with primary care) together with their priority for intervention once their care is scheduled. It is my understanding that the reference to "safety netting processes" means processes in place to protect such patients, such as the need to advise the patient on what to do if their clinical situation changes whilst their care is deferred (for example if they deteriorate or develop new symptoms) so that they know to re-engage with the NHS, and having a system of checking up on those patients whose treatment had been deferred. It could also include having processes in place for people presenting via urgent services with

symptoms that turned out to be cancer, and how the time standards could be met or mitigated.

f) Recommence cancer trials and training and development programmes according to available service capacity.

g) Work with the Wales Cancer Network to ensure a consistent approach regarding access to, and delivery of diagnostics, surgery, systemic anti-cancer therapy and radiotherapy within and across organisations in Wales consistent with nationally agreed best practice (and developing this as a community where this does not exist).

h) Ensure proposals to amend clinical pathways are undertaken using the National ethical framework.

i) Develop or redesign and re-establish services to support patients to keep well whilst awaiting treatment (prehabilitation) and recover following treatment (rehabilitation), to ensure safe and effective treatment during Covid-19 to patients.

j) Ensure good communications and support between primary, secondary and tertiary diagnostic and treatment services in order to support patients, including the timely sharing of information e.g. end of treatment summaries.

582. In May 2020, Public Health Wales developed a plan to restart Bowel Screening Wales using a risk-based, phased approach that was endorsed by Welsh Government. Services restarted from 1 July 2020 and were fully resumed by August 2020. I exhibit the update made by Public Health Wales on the resumption of Bowel Screening Wales at **JPM3WGO02/298 - INQ000469221**.

583. Public Health Wales subsequently developed a plan to mitigate the service backlog through increasing the rate of invitation distribution and increasing laboratory activity. The programme was recovered by October 2021 and able to continue with plans it had put in place prior to the Covid-19 pandemic to reduce the starting age of bowel screening from 60 to 58 years of age. I exhibit a written statement made by the Minister for Health and Social Services, Eluned Morgan, on 11 October 2021 confirming the changes to Bowel Screening Wales at **JPM3WGO02/299 -**

INQ000469222. Public Health Wales has since further reduced the starting age to 51 years of age and increased the test sensitivity with the aim of completing optimisation in October 2024.

584. On 8 July 2020, the then Chief Executive of NHS Wales, Dr Andrew Goodall, chaired a summit of senior NHS leaders to review the impact of the pandemic on cancer services and to agree next steps for recovery of cancer care. I exhibit the notes and actions of the Cancer Recovery Statement on 8 July 2020 at **JPM3WGO02/300 - INQ000469033**. The actions included: implementing the framework for the recovery of cancer services; reconfiguring service delivery; keeping patients safe from Covid-19 when accessing cancer surgery; improving access to surgery; improving diagnostic capacity; improving communication, co-production and reassurance; focusing on innovation; and improvements to demand and capacity modelling. A further national summit was held on 11 February 2021. I have exhibited the notes and actions of the Cancer Recovery Statement held on 11 February 2021 at **JPM3WGO02/301 - INQ000469104.**

585. In March 2021, the Welsh Government published its new policy approach to cancer in the "Quality Statement for Cancer" which I exhibit at **JPM3WGO02/302 - INQ000469102**, and the National Clinical Framework, which I exhibit at **JPM3WGO02/303 - INQ000081910** and includes a National Optimal Pathway for Colorectal Cancer. These documents are designed to guide the NHS in planning cancer services and includes an expectation of an immediate system level focus on recovering the pre-pandemic waiting list volume. I exhibit a copy of the written statement made by the Minister for Health and Social Services, Vaughan Gething, on 22 March 2021 announcing the publication of the Quality Statement and the National Clinical Framework at **JPM3WGO02/304 - INQ000469216.**

586. The broader requirements for the recovery of planned care, including cancer care, are included in "Improving Health and Social Care: Covid-19 Looking Forward" published in March 2021 (exhibited at **JPM3WGO02/305 - INQ000066129**) and "Transforming and Modernising Planned Care and Reducing NHS Waiting Lists" published in April 2022 (exhibited at **JPM3WGO02/306 - INQ000270477**[58]).

[58] 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 [INQ000469146]

Guidance for the care and treatment of lower GI cancer published during the relevant period

587. The Welsh Government recognised that, in view of the disruptions brought about by the pandemic, including reduced staff and bed capacity and reduced access to diagnostics and treatments, health bodies would not be able to deliver all of its cancer services in the same way that they were able to before the Covid-19 pandemic. This was due to a working assumption that there would be significantly less capacity to investigate and treat cancer resulting from the need to redeploy wider NHS services to treat Covid-19, higher levels of staff absence, reduced access to critical care and imaging resulting from Covid-19 care and reduced throughput from enhanced infection and prevention controls. There was also a serious concern about exposing people with cancer, particularly during their treatment procedures, to Covid-19 infection resulting in a higher risk of complications or death.

588. For the purposes of ensuring consistency across Wales, and to make the most clinically appropriate use of the available NHS capacity for cancer care, the Wales Cancer Network published a series of guidance documents which I have referred to earlier in this statement and are outlined in further detail below. Whilst the Welsh Government was not responsible for the development of these guidance documents, it did endorse their use in the NHS in Wales.

589. On 7 April 2020 the Wales Cancer Network published "Cancer Services in Wales during Covid-19" on 7 April 2020 which I have exhibited previously in this statement at **JPM3WGO02/288 - INQ000399069.** As well as providing further information on the types of cancer treatments which must be maintained, the guidance sets out clinical prioritisation criteria for cancer investigations and treatment, broken down by modality: surgery, radiotherapy, and systemic anti-cancer therapy, determined by the degree of the impact of the pandemic on the wider NHS and how this affected the different stages of the cancer pathway. It also outlined a three-phase framework approach:

    i. Acute phase: peak acute service demand due to Covid-19 (0 - 6/8 weeks): Continue to deliver urgent and emergency cancer services.
    ii. 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.

iii. 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.

590. Allocation of healthcare capacity for cancer care is subject to constant local clinical prioritisation, even outside of a pandemic. This is because much of a typical cancer pathway uses specialist care that is not cancer specific, the demand facing NHS services is larger than core capacity, and there are differences in the clinical urgency of cases presenting to the NHS. The pandemic required the capability for the NHS to apply an enhanced level of clinical prioritisation should capacity be significantly impacted. The anticipated effect of the framework for cancer services was that should Local Health Boards and their clinical teams experience significantly less capacity than normal, there would be a common guideline used across Wales to prioritise what capacity was available for those with the greatest clinical need and to reduce as much as possible the potential for avoidable harm. At any one time, the degree to which this guidance would need to be applied – in other words the severity of the local prioritisation – would depend on the extent of the pandemic impact on normal service delivery. It was not possible at the national level to know what specific capacity would be, or how it would change, at each stage of a cancer pathway. The guidance is detailed and nuanced but in general the impact for most cancers would have been that depending on the capacity available on any given day:

a) imaging capacity would have been prioritised for cases with severe symptoms or a higher risk of suspected cancer over those with a lower risk of suspected cancer or requiring routine surveillance procedures.

b) emergency and urgent surgery would have been prioritised over elective routine surgery.

c) systemic anti-cancer therapy with higher rates of curative or life extending effect would have been prioritised over those with lower rates of effect.

d) radiotherapy would have been prioritised for faster developing tumours over less aggressive tumours.

e) where it was safe to do so, particularly in terms of the risk of treating someone unwell with COVID-19, some people's treatment would have been delayed or altered.

f) teaching, training, research, and improvement activity would be deprioritised in favour of maintaining cancer care provision.

591. In June 2020, as the impact of the first wave appeared likely to subside, the Wales Cancer Network published "A Framework for the Reinstatement of Cancer Services in Wales during Covid-19" in June 2020 as exhibited earlier in this statement at **JPM3WGO02/14 – 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 (which would include urgent or emergency 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.

592. The June Framework was premised on a partial return to more normal service delivery following the first wave of the pandemic, although it recognised there could be similar or larger waves in future. It was about moving to the reinstatement of normal services (such as complex surgery) and treatment protocols (such as those temporarily on some form of maintenance therapy in advance of definitive treatment) and where possible the reintroduction of activity such as trials. It also describes how to deliver cancer care in a Covid-19 environment, such as the separation of acute (which would include urgent or emergency services) and elective care staffing.

593. In addition to the guidance provided by the Wales Cancer Network, guidance on the prioritisation of radiotherapy delivery was developed and published by the Clinical Oncology Sub-committee of the Welsh Scientific Advisory Committee. The Welsh Scientific Advisory Committee is one of the seven statutory independent committees

recognised under section 190 of the National Health Service (Wales) Act 2006. These committees provide the Welsh Government with professional advice on public health, service delivery and patient care in Wales. The Welsh Scientific Advisory Committee specifically provides best practice guidance, peer review, situational awareness and strategic advice on scientific issues related to NHS service delivery. The committee also comments on policy options set out by the Welsh Government or provide policy options for the Welsh Government to consider, including advice on risk assessment or management and other ancillary matters such as engaging and communicating with external stakeholders to promote its work. In recognition of the multi-disciplinary nature of health sciences, the Welsh Scientific Advisory Committee has specialist sub-committees with representatives from Local Health Boards, Trusts, professional bodies, Higher Education across Wales who are experts in their fields. The Clinical Oncology Sub-committee is one of these sub-committees.

594. I exhibit a position statement published by the Clinical Oncology Sub-Committee of the Welsh Scientific Advisory Committee on 18 January 2022 at **JPM3WGO02/307 - INQ000469220** which provides guidance for reducing disruption to radiotherapy delivery and prioritisation of radio therapy when there are workforce shortages resulting from the Covid-19. This guidance sets out that radiotherapy prioritisation is centre dependent and staffing dependent but should consider:

a) Maintaining treatment for patients who have started their treatment (gaps to be corrected for on a case by case basis).

b) Delaying or limiting new starts to ensure capacity for patients on treatment particularly where endocrine therapy is a reasonable option, and for low-risk adjuvant treatments.

c) Identifying groups of patients where prolonged delay to starting treatment with the lowest impact on survival and/or quality of life.

d) Consider hypo-fractioned treatments where there is emerging evidence for routine use.

e) Delaying as per priority list.

595. The guidance issued by the Clinical Oncology Sub-Committee of the Welsh Scientific Advisory Committee was similar in principle to the guidance issued by the Wales Cancer Network but was more detailed according to the modality of treatment – in this case, radiotherapy.

596. I have also referred earlier in this statement to the Welsh Government's "Quality Statement for Cancer" exhibited earlier at **JPM3WGO02/302 - INQ000469102** and the National Clinical Framework also exhibited earlier at **JPM3WGO02/303 – INQ000081910**, which includes a National Optimal Pathway for Colorectal Cancer. These replaced the National Cancer Delivery Plan which was in place prior to the pandemic and is exhibited at **JPM3WGO02/308 - INQ000469855**. The main difference between them and the Cancer Delivery Plan was a shift from national planning of actions in relation to cancer services, to local planning of actions (i.e. guiding Local Health Board plans). The Quality Statement for Cancer set out 22 high level commissioning intentions that local NHS organisations should reflect in their local planning. One of these was the requirement to focus on the number of people waiting on a cancer pathway for investigation and/or treatment, which had increased significantly due to the pandemic. The Quality Statement also introduced a series of nationally agreed pathways for different types of cancer to support the local planning of services according to a common point of reference, including a pathway for colorectal cancer. The National Clinical Framework is a wider and higher-level description of how clinical services in Wales should be developed. For instance, it described how clinical networks would form part of a new organisation called the NHS Executive and provide national guidance for NHS organisations and use data to create a learning health and care system. Welsh Government also published the Quality and Safety Framework in September 2021 which I exhibit at **JPM3WGO2/309 - INQ000469879**. This document outlined expectations that organisations arrange their functions into quality management systems and laid out the various ongoing actions and innovations to improve care quality that needed to be completed. The principles within this document were consistent with those in the National Clinical Framework.

Data relating to lower GI cancer during the relevant period

597. I have been asked to provide the annual number of patients in Wales undertaking screening for lower GI cancer during the relevant period, and the annual number of

patients in Wales undertaking screening in the three years prior to the Covid-19 pandemic.

598. Information about the annual number of patients in Wales undertaking screening for lower GI cancer is collected by Public Health Wales. The information provided to the Welsh Government in this respect is as follows:

    a) April 2017 – March 2018: 286,427 participants were invited for bowel screening and 167,337 tests were validated, with an average uptake of 55.7%.

    b) April 2018 – March 2019: 283,622 participants were invited for bowel screening and 175,215 tests validated, with an average uptake for screening of 57.3%.

    c) April 2019 – March 2020: 280,193 participants were invited for bowel screening and 164,050 people were screened, with an average uptake for screening of 58.5%.

    d) April 2020 – March 2021: 182,710 participants were invited for bowel screening with 116,520 people screened, with an average uptake of 63.8%.

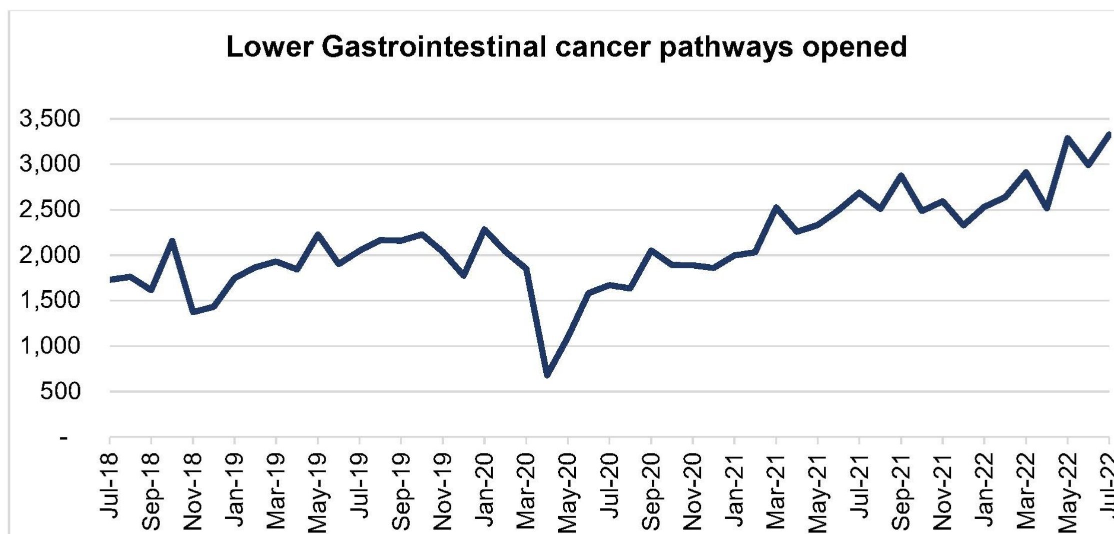
599. Full data is not yet available for the period April 2021 – March 2022. However, Public Health Wales has informed the Welsh Government's Wales Screening Committee that the number of samples sent to laboratory during the recovery from the pandemic was consistently over usual pre-Covid activity due to the increased number of invitations and a higher uptake following restart (65%), with an average of 20,956 samples received each month from March 2021 to February 2022. Screening uptake between October 2021 and September 2022 was 66.6% (annual coverage 64%) with 226,000 screening kits analysed.

600. I have been asked to provide cancer waiting times data on the number of people being referred for suspected lower GI cancer during the relevant period and in the three years prior to the Covid-19 pandemic.

601. The Welsh Government publishes monthly referral and treatment data for cancer pathways, broken down by cancer type. I have provided below a graph showing the lower GI pathways opened up on the suspected cancer pathway by month from July 2018 to July 2022 (the earliest available data is from July 2018). However, in December 2020, the pathway measure was merged from two measures (Urgent

Suspected Cancer and Non-Urgent Suspected Cancer) to one measure (Suspected Cancer Referral) with revised definitions and targets. I exhibit a written statement made by the Minister for Health and Social Services, Vaughan Gething, on 18 November 2020 at **JPM3WGO02/310 - INQ000469223**. This statement explains that the single cancer pathway was introduced with widespread clinical support because it was found to be a much more accurate way of measuring the times to treatment patients were experiencing in the health system. Accordingly, the data prior to December 2020 is not directly comparable to the data after this point.

Figure 7: Graph showing lower GI pathways opened on the suspected cancer pathway by month

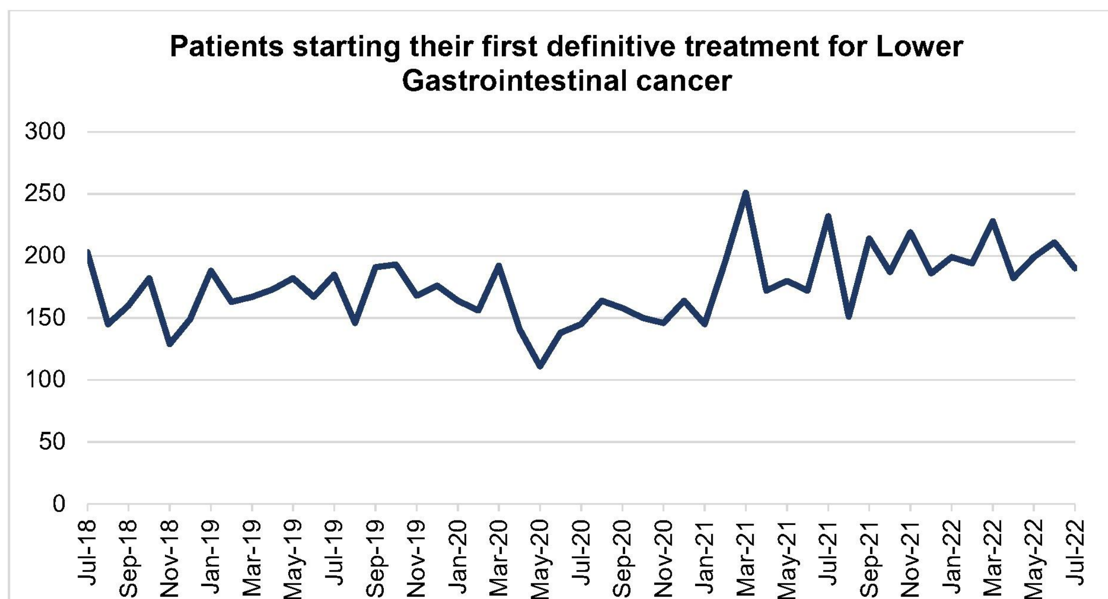


602. I have been asked to provide the annual number of patients who received a positive diagnosis of lower GI cancer during the relevant period, and the annual number of patients who received a positive diagnosis of lower GI cancer in the three years prior to the Covid-19 pandemic.

603. The Welsh Government does not hold this information, which is held by Public Health Wales.

604. However, the Welsh Government does publish monthly data on the number of people starting their first definitive treatment. I have provided below a graph showing the number patients starting their first definitive treatment by month from July 2018 to July 2022 (the earliest available data is from July 2018).

Figure 8: Graph showing patients starting their first definitive treatment for lower GI cancer by month



605. I have been asked to describe NHS waiting time targets in Wales relating to lower GI cancer during the relevant period.

606. Prior to February 2021, the NHS cancer targets were set out in the Welsh Health Circular: Consolidated rules for managing cancer waiting times which I exhibit at **JPM3WGO02/311 - INQ000469279**. The targets were:

a) Urgent Suspected Cancer Pathway: 95% of patients should start first definitive treatment within 62 days of receipt of referral.

b) Non-Urgent Suspected Cancer Pathway: 98% of patients should start their first definitive treatment within 31 days of the decision to treat.

607. As referred to earlier in this section, in December 2020, the pathway measure was merged from two measures (Urgent Suspected Cancer and Non-Urgent Suspected Cancer) to one measure (Suspected Cancer Referral) with revised definitions and targets, as explained in the written statement made by the Minister for Health and Social Services, Vaughan Gething, on 18 November 2020 previously exhibited at **JPM3WGO02/310 - INQ000469223**.

608. Following the written statement, the NHS in Wales replaced the above targets with a single target for Suspected Cancer Referral: at least 75% of people should start first definitive treatment within 62 days of the point of suspicion.

609. These are the only cancer-specific targets imposed by the Welsh Government. However, there are operational good practice targets which form part of the optimal pathway work requiring that people on a routine diagnostic pathway are subject to an eight-week target.

610. I have set out below a graph showing the number of patients starting their first definitive treatment for lower GI cancer within target time month by month between July 2018 (the earliest available data is from July 2018) to July 2022. I have also added a graph showing the percentage of patients starting their first definitive treatment for lower GI cancer within target time month by month for the same period. However, given the change from two cancer pathways to one cancer pathway in December 2020, the data provided after December 2020 is not comparable to that before.

Figure 9: Graph showing patients starting their first definitive treatment for lower GI cancer within target time by month

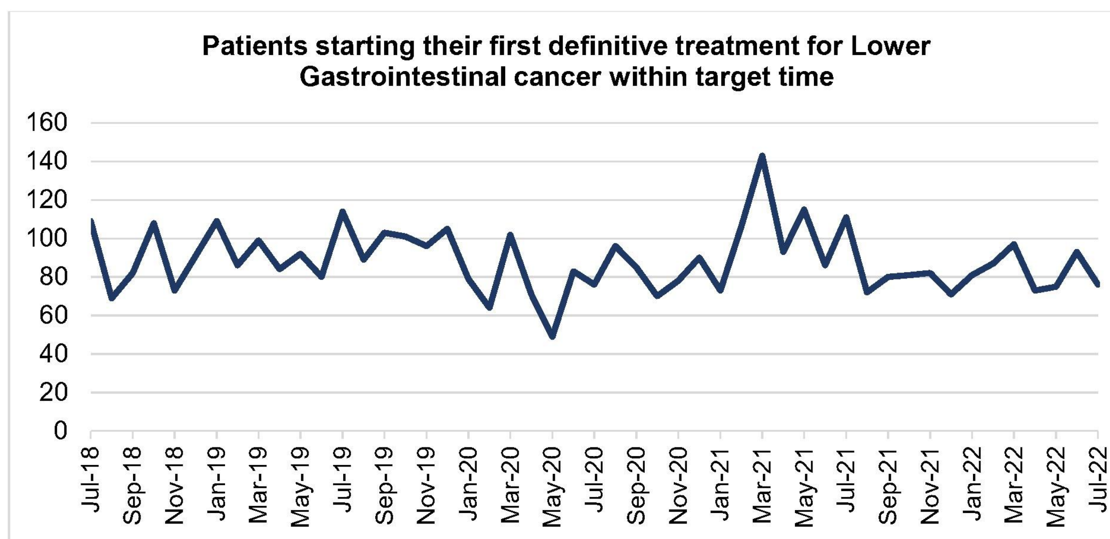
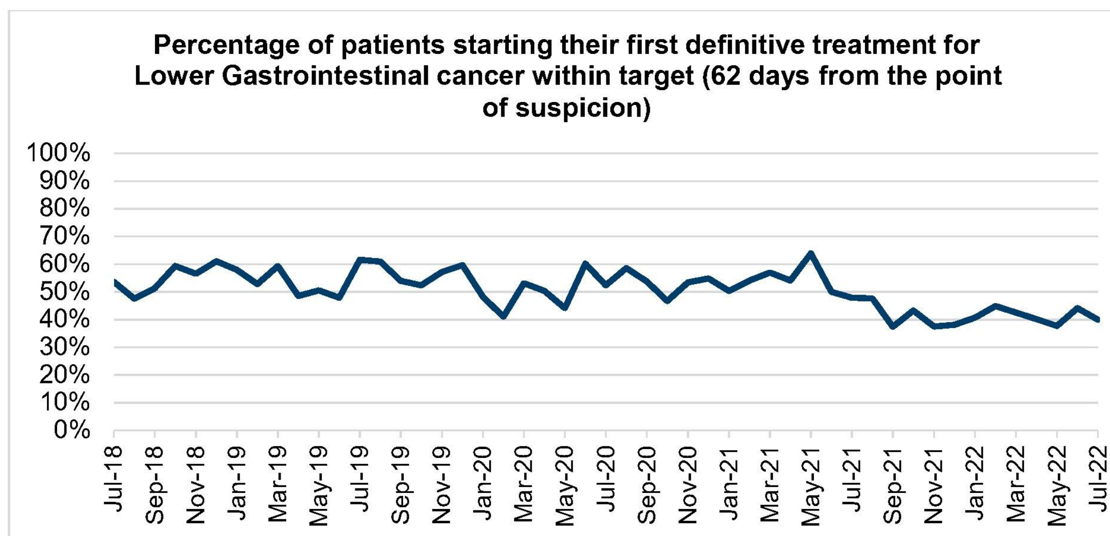


Figure 10: Graph showing the percentage of patients starting their first definitive treatment for lower GI cancer within target time by month



611. 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 at **JPM3WGO02/312 - INQ000227380.**

612. I have been asked to provide the number and percentage of cancelled treatments for lower GI cancer in Wales during the relevant period. Although the Welsh Government received monthly reports from Local Health Boards which included some information about delayed and cancelled treatment, the relevant data is held by Local Health Boards.

613. I have been asked to describe any changes during the relevant period in the number or percentage of patients first presenting with lower GI cancer at an advanced stage or with metastatic disease, compared to first presentations in the three years preceding March 2020.

614. The Welsh Government does not hold data on stage at diagnosis for any type of cancer. Such information is held by Public Health Wales. Making links between stage of cancer at diagnosis or NHS time to treatment and population outcomes is complex and subject to significant uncertainty. In general, earlier stage cancer and more rapid

access to treatment is associated with better outcomes but it becomes more complex when considering specific cancers with different degrees of clinical urgency, the data quality of the period selected, the service models involved, and the nature of the treatments given.

615. For instance, there has been a general long-term trend for the proportion of non-staged cancers to fall. This category reflects missing data or patients where it is not possible or clinically appropriate to stage the cancer. As recently as 2015, almost 16% of colorectal cancers were recorded without stage, but this has since fallen to around 6-8%. This will impact the proportions recorded at stages 1-4. There has also been a long-term increase in the proportion diagnosed at stage 4, rising from 17% in 2011 to 25% in 2019. There is also normally some random variation when comparing calendar years. Therefore, it is difficult to draw any firm conclusions to what degree the pandemic impacted stage at diagnosis in 2020. The data shows a small decrease in the proportion diagnosed at either stage 1, 2 or 3 and a small increase in the proportion diagnosed at stage 4 or as non-staged. What the proportions do not show, is that the overall number of cases fell noticeably and the reason for this fall could skew the proportions of patients that presented at different stages. For instance, it could be argued that the interruption to the bowel screening programme, changes in access to general practice and emergency departments, and changes in public behaviour may have all contributed to fewer early-stage colorectal cancers being diagnosed in 2020. It is also likely that many cases that may have been expected to present in 2020 were identified in subsequent years but we don't yet have official statistics for cancer incidence in 2021-22. The impact of the pandemic on stage at diagnosis is not yet clear but is likely to have been a significant factor in the following two outcomes:

a) The crude (i.e. non-age standardised) mortality rate for colorectal cancer per 100,000 people increased from 30.0 in 2019 to 30.6 in 2020 and 31.2 in 2021.

b) One year net survival for colorectal cancer decreased from 74.9% in 2019 to 70.8% in 2020.

616. The extent to which time to treatment was a factor is probably unquantifiable due to data limitations, changes to dataset resulting from the introduction of the single suspected cancer pathway in December 2021, and the difficulty in attributing the impact of the length of treatment wait to actual patient outcome. For instance, a

pathway delay spanning several weeks may not make a difference to a person's treatment outcome if their cancer is less aggressive and their fitness for treatment does not deteriorate. Conversely, a cancer that may change stage or result in a person no longer being able to tolerate treatment would be expected to have a poorer outcome. The 62-day timeframe for the cancer pathway is a marker of NHS performance for all cancers rather than an individual's clinical urgency. Although it cannot be compared to prior to the pandemic, between January 2021 and June 2022, 44% of people with colorectal cancer started first definitive treatment within 62 days of the point of suspicion, against a general target of 75%.

The role of private healthcare providers in relation to lower GI cancer during the relevant period

617. Whilst private hospital capacity was commissioned on a national basis 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 Welsh Health Specialised Services Committee and its NHS partners.

618. The Welsh Government encouraged the use of private sector capacity which had been secured through Welsh Government funding (see for example the letter from Dr Andrew Goodall dated 1 April 2020 as exhibited at **JPM3WGO02/294 - INQ000227390)**. However, whether the Local Health Boards utilised such private sector capacity was a local decision for each individual Local Health Board based on their clinical need to maintain essential services. As such the Welsh Government does not hold any information on the number and percentage of NHS patients who received treatment and care through the private sector, nor the types of treatments or care for lower GI cancer provided to NHS patients by private healthcare, nor the percentage of these patients who received treatment within the target timeframes.

The impact of IPC measures and shielding advice on lower GI cancer

619. The Welsh Government did not introduce specific guidance in relation to colorectal cancer other than the general Infection Prevention and Control Guidance for safe clinical practice. It was therefore subject to local decision how they implemented the advice based on the clinical infection risk and the clinical needs of patients for treatment. In general, however, the Welsh Government is aware that enhanced infection prevention and control measured reduced the capacity for the provision of diagnostic and care pathways for lower GI cancer, for instance through the need to

create distance between treatment chairs for systemic anti-cancer therapy, the need to divide existing treatment equipment, staffing and waiting areas into dedicated capacity for Covid-19 negative and Covid-19 positive patients, or to allow time for sufficient air changes in endoscopy suites. More widely, reduced access to theatres and key staff groups, and new infection prevention and control procedures, have reduced capacity and productivity for cancer surgery.

620. Whilst the Welsh Government did not issue any specific guidance amending the diagnostic and care pathways for lower GI cancer, gastrointestinal cancer pathways, bowel screening and endoscopic surveillance have been significantly disrupted as a result of guidance from the British Society of Gastroenterology to pause all non-emergency endoscopy due to its classification as an AGP. The Welsh Government did not have any involvement in the development of that guidance by the British Society of Gastroenterology.

621. On 5 May 2020, a workshop was held by the Welsh Government to discuss safeguards to conduct safe elective endoscopy sessions in adults was held. I exhibit the notes from the workshop at **JPM3WGO02/313 - INQ000469000.** At the meeting, safeguards were agreed including triaging patients, screening patients, maintaining social distancing. These documents were considered by the Welsh Association for Gastroenterology and Endoscopy and I exhibit a copy of their response at **JPM3WGO02/314 - INQ000468993** and Public Health Wales's response at **JPM3WGO02/315 - INQ000469005.**

622. As described earlier in this statement, actions to mitigate the impact of Covid-19 on the provision of cancer services more generally were set out in "A Framework for the Reinstatement of Cancer Services in Wales during Covid-19" in June 2020 which I exhibited earlier at **JPM3WGO02/14 - INQ000353461.**

623. I have been asked about the impact on immuno-compromised lower GI cancer patients. National guidance was available for immuno-compromised patients, though this was more general rather than specific for lower GI patients. Clinical risk and clinical need for treatment was specific to individual patients and their clinician, and the Welsh Government expected that this would be discussed with patients throughout their pathway.

Innovative solutions to ensure lower GI cancer pathways were maintained during the pandemic

624. The Welsh Government is unable to comment on any local solutions which may have been put in place by individual Local Health Boards and NHS Trusts. In terms of national solutions these include the introduction of national video consultations for outpatients which were helpful in improving service efficiency. Furthermore, at the Cancer Summit Recovery which was held on 8 July 2020, the need for a focus on innovation was highlighted in order to support cancer reform and improve pathways. The use of Faecal Immunochemical Tests to triage lower GI cancer referrals into higher and lower risk to help prioritise the available colonoscopy capacity are examples. Local Health Boards were encouraged to continue this transformation through the use of information technology and the configuration of services through regional and national approaches. The notes from the Cancer Summit Recovery were exhibited earlier at **JPM3WGO02/300 - INQ000469033**. The Wales Cancer Network, with whom the Welsh Government worked very closely, was also a key support to support innovative clinical practice.

<u>Hip replacement surgery/elective orthopaedic surgery</u>

625. The Inquiry has asked me for information about hip replacement surgery and/or elective orthopaedic surgery. In order to address these questions, I have received support from Professor Chris Jones, Deputy Chief Medical Office for Wales

Steps taken to enable hip replacement surgery to be maintained during the relevant period

626. As set out earlier in this statement, on 13 March 2020, the Minister for Health and Social Services issued a framework of actions exhibited earlier at **JPM3WGO02/58 - INQ000320755** which enabled Local Health Boards to pause some routine activities in order to prepare for an increase in Covid-19 demand by allowing services and beds to be reallocated and for staff to be redeployed and retrained in priority areas. Such routine activities included the suspension of non-urgent surgical admissions and procedures, which could include hip replacement surgery depending on the clinical circumstances. However, any hip replacement surgery which was deemed to be clinically urgent was required to continue where it was safe to do so.

627. The requirement for continuing to deliver urgent surgery including access to urgent diagnostics and related rehabilitation was also set out in guidance issued by the Essential Services Group within the Welsh Government "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 4 May 2020 and exhibited earlier at **JPM3WGO02/08 - INQ000182443** and updated on 12 June 2020, also exhibited earlier at **JPM3WGO02/16 - INQ000182461**, which were required to be read respectively with Quarters 1 and 2 NHS Wales Operating Framework as exhibited earlier in the statement. In the guidance dated 12 June 2020, hip fracture surgery was explicitly identified as an essential service which must continue.

628. These arrangements were consistent with the Welsh Government's guidance which was in place prior to the pandemic on critical care escalation management of large unplanned increases in demand. I have previously exhibited a copy of the guidance dated 30 January 2016 at **JPM3WGO02/32b – INQ000469291** and a Welsh Health Circular dated 30 January 2017 I exhibit at **JPM3WGO02/316 - INQ000469188**. Within that guidance it was anticipated that in times of increased demand, the temporary cancellation of all elective non-life-threatening surgery may be necessary but that urgent services must continue. The requirement for maintaining essential services is also entirely consistent with the advice from the Welsh Government Organisation and professional bodies.

629. Whilst the requirement remained for all urgent surgery to continue, there was a recognition that resources were limited and that clinical decisions would have to made in relation to the allocation of the surgical resources available and the assessment and treatment of individual patients. To support clinical decision making in that regard, the Welsh Government endorsed the use of NHS England's "Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic" dated 11 April 2020. I exhibit a copy of NHS England's Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic at **JPM3WGO02/317 - INQ000226460**[59], which classified patients requiring surgery during the pandemic into the following five categories:

a) Priority Level 1a Emergency – operation needed within 24 hours;
b) Priority level 1b Urgent – operation needed within 72 hours;
c) Priority level 2 – surgery that can be deferred for up to 4 weeks;

[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 [INQ000399073]

d) Priority level 3 – surgery that can be delayed for up to 3 months;
e) Priority level 4 – surgery that can be delayed for more than 3 months.

630. Elective hip replacement surgery was by definition not considered to be urgent and as such it was for Local Health Boards to decide whether to continue to provide such elective surgery based on an assessment of whether it could be done safely and without compromising their ability to respond to Covid-19 patients and deliver essential services. However, in accordance with the Clinical Guide to Surgical Prioritisation as set out above, more urgent surgery would been prioritised. Inevitably, there would have been a marked decrease in the delivery of elective hip replacement surgery across Wales and particularly so in the early part of the pandemic.

631. Whilst it remained a matter of local decision whether to restore more routine surgical procedures such as elective hip replacement surgeries, the Welsh Government encouraged and expected Local Health Boards to adopt a progressive approach to restoring services. The NHS Operating Frameworks outlined several factors which must be taken into account in restoring services such as covid activity data, safety, workforce, capacity, clinical support requirements and risks for patients. The Quarter 2 NHS Framework also endorsed the "Recovery of surgical services during and after Covid-19" published by the Royal College of Surgeons and exhibited at **JPM3WGO02/318 – INQ000408892**[60]. This document provided a list of principles, recommendations and key considerations in order to facilitate the resumption of elective surgery. The recommendations were structured under nine themes to allow services to provide safe and efficient patient care, but also to ensure that when surgery resumes, it does not have to stop again. These nine themes were:

a) Key considerations before resuming elective services;
b) Developing cohesive leadership and process of frequent communication;
c) Assessing surgical workload and patient population;
d) Ensuring adequate hospital capacity and facilities;
e) Enhancing workforce capacity;
f) Reconfiguring services;
g) Supporting the surgical workforce;
h) Patient communication; and

[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 [INQ000469158]

i) Supporting training.

632. Throughout the pandemic, the Welsh Government was conscious of the impact of the pandemic on the availability of treatment for non-Covid-19 matters, particularly whilst the response and contingency arrangements for Covid-19 were at the highest escalation. In May 2021, the then Chief Executive of NHS Wales, Dr Andrew Goodall, and the Chief Medical Officer for Wales, Sir Frank Atherton, met with the Welsh Orthopaedic Board to discuss the development of an orthopaedic strategic programme for the aim of recovering orthopaedic services alongside any Covid-19 resurgence. The Welsh Orthopaedic Board was established in 2014 for the purpose of supporting the delivery of planned care and is comprised of health professionals in orthopaedics from across Wales, including officials from the Welsh Government. I have exhibited a copy of a letter sent from Dr Goodall dated 9 June 2021 referring to that meeting at **JPM3WGO02/319 - INQ000469239** which confirmed his support for the development of a strong orthopaedic strategic programme. I have also exhibited minutes from a meeting of the Welsh Orthopaedic Board on 28 May 2021 at **JPM3WGO02/320 - INQ000469237.** These note that the overarching message from the meeting with Dr Andrew Goodall and Sir Frank Atherton was that the plans being received from Local Health Boards for recovery were not ambitious enough and that there was a desire to use the Welsh Orthopaedic Board as a clinical reference group to inform decision making.

633. In September 2021, the Welsh Orthopedic Board, on behalf of the Welsh Government, commissioned the Welsh Orthopaedic Society to develop the National Clinical Strategy. The National Clinical Strategy for Orthopaedics was subsequently published on 31 March 2022, and I exhibit that strategy at **JPM3WGO02/321 - INQ000469236**. This Strategy provides 34 immediate actions for Local Health Boards to enact to prevent ongoing patient harm, 155 recommendations to ensure transformation of subspecialty clinical pathways and a long-term blueprint for the future provision of orthopaedic services. I also exhibit Annex 6 to the National Clinical Strategy for Orthopaedics which sets out 23 actions for hip surgery at **JPM3WGO02/322 – INQ000469240**.

Clinical guidance and/or guidelines relevant to hip replacement surgery

634. Aside from issuing strategic overarching guidance on maintaining essential services as set out above in this statement, the Welsh Government did not publish nor have

any involvement in the development of any clinical guidance or guidelines relevant to hip replacement surgery or elective orthopaedic surgery during the relevant period. Although the Welsh Government endorsed the use of the "Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic" published by NHS England, which I have outlined earlier in this statement, the Welsh Government did not have any involvement in the development of this guidance. The clinical guidance supported by Wales was developed by the relevant national clinical bodies, which also represented Welsh clinicians. This was recognised by clinicians as relevant for management of clinical risk when it was not possible to treat patient care within the previous national access targets.

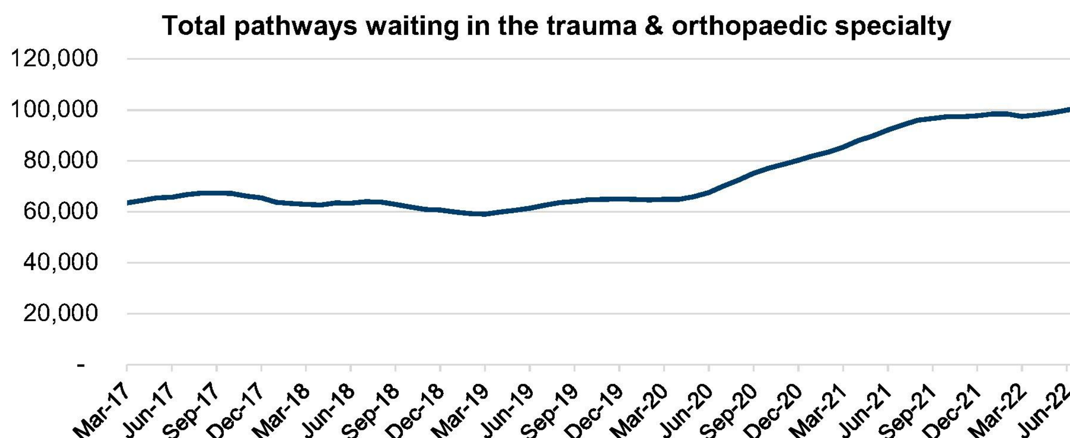
Data relating to hip replacement surgery during the relevant period

635. I have been asked to provide information on the annual number of patients waiting for hip replacement surgery during the relevant period and the annual number of patients awaiting this surgery in the three years prior to the Covid-19 pandemic.

636. Since 2009, the Welsh Government has published monthly data on NHS Referral to Treatment Times which measures the total waiting time from GP referral to treatment and this is now the main source of information on NHS waiting times. That information is collected locally by each Local Health Board through an agreed data standard and is subsequently sent to Digital Health and Care Wales which consolidates the data for the Welsh Government by specialty level rather than individual procedure level. Welsh Government collects this data for the purposes of supporting performance management of targets and publication of national statistics.

637. I have provided below a graph showing the pathways waiting for trauma and orthopaedic surgery between March 2017 and July 2022:

Figure 11 Graph showing total pathways waiting in the trauma and orthopaedic specialty by month



638. The Welsh Government does not hold any data on the annual number of patients in Wales who received hip replacement surgery or elective orthopaedic surgery during the relevant period or in the three years prior to the pandemic. Such information would be available from Digital Health and Care Wales.

639. I have been asked to provide details of any assessments made by or with the collaboration of the Welsh Government of the impact of any delays to hip replacement surgery.

640. The Welsh Government was acutely aware of the impact of the pandemic on the availability of treatment for non-Covid-19 matters including hip replacement surgery and, as set out above, subsequently commissioned the development of the National Orthopaedic Strategy for the purposes of recovering and improving orthopaedic services. The National Orthopaedic Strategy was effectively borne out of the impact of pandemic on orthopaedic surgery, including delays, and its recommendations (which included the creation of three orthopaedic hubs across Wales) were made with the aim of improving service delivery and patient experience and supporting the future sustainable model of orthopaedics. This Strategy recognised that local services were required by each Local Health Board for routine high demand services, however for some areas such as high-volume low acuity treatment provision or specialist treatment such as spinal treatment a regional approach would best support future recovery and sustainability. In Wales we have three main health service delivery regions: South West Wales (comprising Hywel Dda University Health Board and Swansea Bay University Health Board); South East Wales (comprising Cardiff and

Vale University Health Board, Aneurin Bevan University Health Board and Cwm Taf Morgannwg University Health Board); and North Wales (comprising Betsi Cadwaladr University Health Board which is recognised as a region due to its size and geography). It is considered that a "regional approach" – which means Local Health Boards working together within a health service delivery region – is more effective to concentrate clinicians and services and support value for money to avoid duplication in each Local Health Board area. Wales does not have any orthopaedic specific hospitals, although some Local Health Boards have, since before the pandemic, operated ring fenced elective orthopaedic treatment facilities located away from the emergency admitting hospitals (e.g. Cardiff and Vale University Health Board and Aneurin Bevan University Health Board). The National Orthopaedic Strategy resulted in the development of regional plans, which embedded the 'Get it Right First Time' recommendations on service delivery. The work on improving service delivery is managed through the National Clinical Network of the Planned Care Programme and supported by the Orthopaedic Clinical Implementation Network.

641. The ministerial orthopaedic summit held in August 2022 also played a key role in analysing the impact of delays to orthopaedic surgery, and in improving service delivery. I exhibit a letter from Minister of Health and Social Services dated November 2022 outlining the outcomes of the summit at **JPM3WGO02/323 – INQ000469299** which includes requiring Local Health Boards to place those waiting over 104 weeks in the same category as urgent appointments and making additional capacity available at other hospitals to enable more elective surgeries to be carried out.

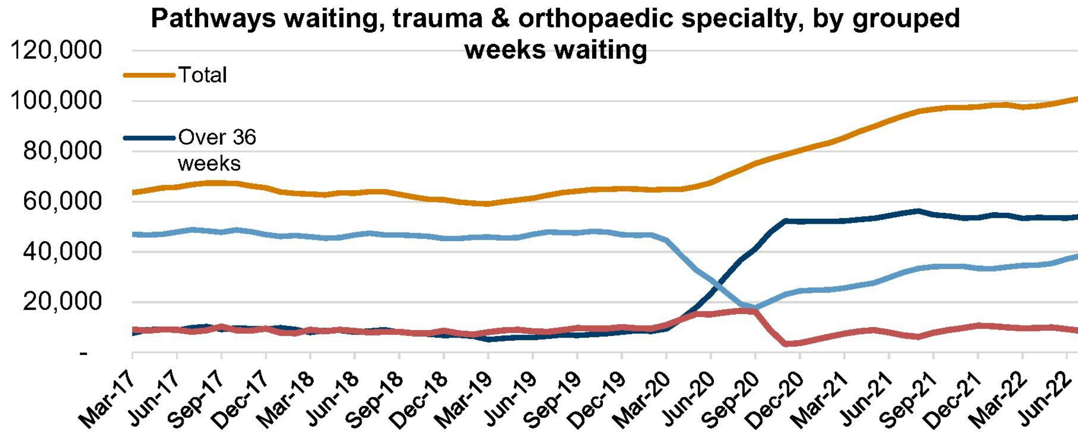
642. I have been asked to provide details of the targets for the wait times for hip replacement surgery.

643. Prior to the Covid-19 pandemic, the Welsh Government's policy on referral to treatment times required that 95% of pathways from referral to start of treatment should be waiting less than 26 weeks, and 100% should be waiting less than 36 weeks. This is a total target measuring the time from referral to secondary care to the start of treatment.

644. These referral to treatment times continued during the relevant period, but the Welsh Government was fully aware of the impact that the pandemic had on waiting lists with routine capacity greatly reduced.

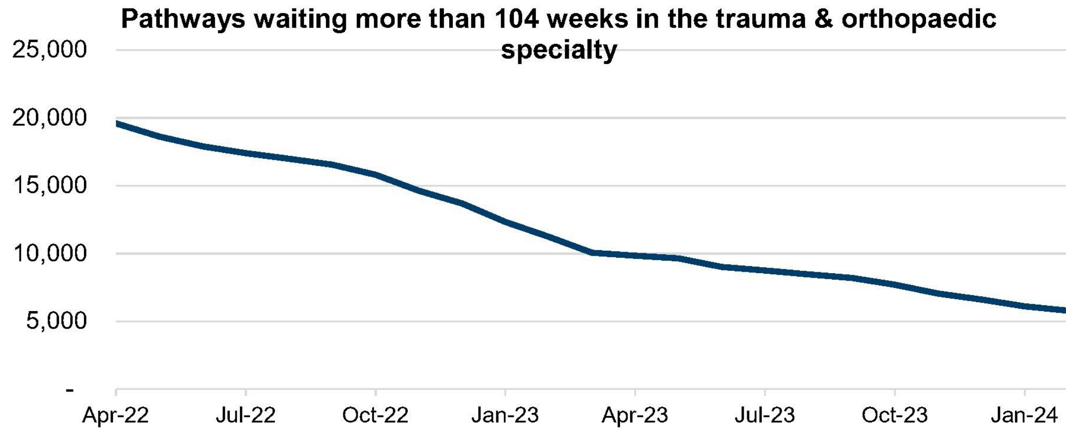
645. I have provided below a graph showing the pathway waiting times for trauma and orthopaedic surgery between March 2017 and July 2022. The Welsh Government does not hold specific data on an individual procedure level.

Figure 12: Graph showing the pathway waiting times for trauma and orthopaedic surgery



646. In April 2022, the Welsh Government published "Transforming and Modernising Planned Care and Reducing NHS Waiting Lists" which I exhibited earlier at **JPM3WGO02/306 – INQ000270477** and sets out the Welsh Government's plans for reducing waiting times for people in Wales. Since then, the Welsh Government have set the following additional targets requiring that 97% of patients should be waiting less than 104 weeks by the end of 2023 and 99% of patients should be waiting less than 104 weeks by March 2024. I have set out a graph below showing the number of pathways waiting more than 104 weeks in the trauma and orthopaedic specialty between April 2022 and February 2024:

Figure 13: Graph showing the number of pathways waiting more than 104 weeks in the trauma and orthopaedic specialty



647. I have been asked to provide information on the number and percentage of cancelled hip replacement operations during the relevant period. The Welsh Government does not hold any data on this.

The role of private healthcare providers in relation to hip replacement surgery during the relevant period

648. Whilst private hospital capacity was commissioned on a national basis 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 Welsh Health Specialised Services Committee and its NHS partners. Whether the Local Health Boards utilised such private sector capacity in providing hip replacement surgery depending on their respective clinical needs. As such, the Welsh Government does not hold any detail on the number and percentage of the NHS in Wales patients receiving hip replacement surgery in this way or the percentage of these patients who received treatment within the target timeframes. Neither does the Welsh Government hold any data on whether elective orthopaedic surgery was provided to the NHS in Wales patients by the independent health sector prior to 1 March 2020.

649. The Welsh Government also does not hold any data on the percentage of hip replacement surgery/elective orthopaedic operations carried out each year in Wales which were privately funded during the relevant period or in the preceding three years and is therefore unable to comment on the impact of a fluctuation in the percentage of privately funded operations on the waiting list and waiting times for orthopaedic surgery.

The impact of IPC measures on elective orthopaedic surgery

650. During all phases of the Covid-19 pandemic, health and social care providers in Wales were asked to adhere to the UK IPC guidance. How it was implemented was ultimately down to each Local Health Board depending on their local infrastructure and estate. However, generally speaking, the Covid-19 IPC guidance would have meant a different way of working for all hospitals in the way that they delivered healthcare services. For surgical services such as elective orthopaedic surgery this would have meant a reduction in the number of operations because of the time required to clean and change PPE between each patient, undertake cleaning and the implications of using laminar flow theatres.

651. As set out earlier in this statement, the decision to provide non-urgent services such as elective hip replacement surgery was a local decision for Local Health Boards based on an assessment of whether it could be done safely and without compromising their ability to respond to Covid-19 patients and deliver essential services. In assessing whether they could safely provide such services, Local Health Boards would have considered whether they could do so whilst also adhering to IPC measures. This was reflected in the NHS Operating Frameworks referred to earlier in this statement, and in the Royal College of Surgeon's guidance on the recovery of surgical services also outlined earlier.

652. IPC measures were universal for services for general management of safe services and restart of services. Local management on what services started when and how was dependent on how they could safely restart services within the local estate to comply with the national IPC measures.

Innovative solutions to ensure hip replacement surgery was maintained during the pandemic

653. I have been asked to describe any innovative solutions to ensure hip replacement surgery was maintained during the pandemic. Whilst the Welsh Government generally promoted the use of virtual (telephone/audio) appointments for use with clinical consultations and outpatient appointments, we recognised the limitations with such technology within the context of hip replacement services. This is because the nature of orthopaedics requires physical examination and manipulation of joints in order to access clinical acuity. The Welsh Government did however promote the use

of group consultation services for pre-op education classes and the use of digital services to support people while waiting for hip operations.

<u>**Heart disease and heart attacks**</u>

654. The Inquiry has asked me for information about heart disease and heart attacks. In order to address these questions, I have received support from Professor Chris Jones (Deputy Chief Medical Officer for Wales) and the relevant Welsh Government policy team.

Steps taken to enable risk assessments, diagnostic testing and treatment for heart disease to be maintained during the relevant period

655. As set out earlier in this statement, on 13 March 2020, the Minister for Health and Social Services issued a framework of actions previously exhibited earlier at **JPM3WGO02/58 - INQ000320755.** This enabled Local Health Boards to pause some routine activities in order to prepare for an increase in Covid-19 demand by allowing services and bed to be reallocated and for staff to be redeployed and retrained in priority areas. This included suspending non-urgent surgical admissions and procedures and non-urgent outpatient appointments, but any essential services were required to continue. Therefore, any risk assessments, diagnostic testing and treatment for heart disease which were considered to be elective or routine services, such as elective heart surgery, cardiac catheterisation and outpatients could be suspended, whereas any urgent cardiac services such as patients presenting with ST-elevation myocardial infarction were maintained.

656. The requirement for continuing to provide to essential services was also set out in "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 4 May 2020 and exhibited earlier in this statement at **JPM3WGO02/08 - INQ000182443** which was to be read with Quarter 1 NHS Wales Operating Framework. This required the continuation of life saving intervention including access to urgent diagnostics and related rehabilitation which expressly included urgent interventional cardiology e.g. primary percutaneous coronary intervention (PCI) and acute coronary syndromes such as non-STEMI (NSTEACS) and unstable angina (urgent treatment).

657. In the updated "Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential" dated 12 June 2020 also

exhibited earlier in the statement at **JPM3WGO02/16 - INQ000182461**, the list of cardiac services which must be maintained for patients needed essential cardiology or cardiac surgery intervention was updated for the following conditions: myocardial infarction; class IV heart failure; arrhythmias (such as uncontrolled atrial fibrillation (AF) or ventricular tachycardia (VT); acute coronary syndromes such as non-STEMI and unstable angina; endocarditis; and aortic stenosis. The Guidance also stated that services must also include access to:

a) Rapid access clinicals which can prevent admission or facilitate early discharge;

b) Admission and ongoing management with pathways expedited to allow rapid treatment and discharge;

c) Appropriate and timely level of essential diagnostics: electrocardiography (ECG); echocardiography (ECHO); 24 Hour ECG or event monitoring; computed tomography (CT) coronary angiogram; invasive coronary angiogram; stress/exercise tolerance test; doppler stress echo (DSE); myocardial perfusion scanning; cardiac CT/magnetic resonance imaging (MRI).

d) Appropriate intervention: cardiac surgery; implantable cardiac defibrillator (ICD) implantation; cardiac ablation; PCI; NSTEMI; primary PCI (PPCI); congenital heart surgery; transcutaneous aortic valve implantation (TAVI).

e) Rehabilitation.

658. These changes were made to reflect the Essential Service Guide on Cardiac Specialised Services which was published by the Welsh Health Specialised Services Committee on 7 May 2020 and exhibited at **JPM3WGO02/324 – INQ000469211.** In view of the potential limitation on resources because of the pandemic, the Guide set out a proposed delivery approach for essential cardiac services through a coordinated staged approach as illustrated by the figure below. The Guide provided guidance on how Local Health Boards should plan to deliver essential services at each stage, whereby amber and red status would trigger regional and national surge plans, respectively. The Guide also set out at Appendix 2 the cardiology service provision that was available across Local Health Boards in April 2020.

Table 19: Table showing a coordinated staged approach for essential cardiac services

Table 1.		
Available	Capacity Available at provider centre	Treatment currently available at local site
Limited	Capacity expected to be reached imminently **Regional or Supra regional response**	Treatment currently available but in limited supply. Capacity may soon be exceeded if high demand either due to number of cardiac patients or surge in COVID 19
Severely limited capacity	Capacity reached **National Response**	Treatment at capacity. Demand exceeds supply of treatment. Prioritisation is essential. Treatment available only to those patients with highest capacity to benefit quickly.

659. These arrangements on the continuation of essential services were consistent with the Welsh Government's guidance which was in place prior to the pandemic on critical care escalation management of large unplanned increase in demand exhibited previously at **JPM3WGO02/32b – INQ000469291.** This guidance also provided that elective non-life-threatening cardiothoracic surgery should be prioritised over the cancellation of other elective non-life-threatening surgery (with the exception of major oncology, vascular and neurosurgery). The Welsh Government has no reason to believe that this guidance was not adhered to during the Covid-19 pandemic but does not have detailed information about its operational application.

660. Notwithstanding the requirements on NHS health bodies in Wales to continue to provide urgent cardiac services as set out above, the Welsh Government is entirely aware that the response to the Covid-19 pandemic had a major impact on all parts of the cardiovascular disease pathway – from a significant reduction in attendances for urgent and emergency care, deferral of diagnostic procedures and therapeutic interventions, reduced access to specialised care in the community and identification and management of risk factors for cardiovascular disease. In most of the district general hospitals in Wales, cardiologists were part of the front line Covid-19 response. In view of that, and at the earliest opportunity, the Welsh Government took steps to recover cardiac services alongside any Covid-19 resurgence.

661. On 29 June 2020, Dr Andrew Goodall wrote to NHS Wales Chief Executives and Medical Directors exhibited at **JPM3WGO02/325 - INQ000469023** outlining the need to reinstate some routine services to minimise the harm to patients and requiring that Local Health Boards increase the provision of urgent diagnosis, treatment and care in order to avoid preventable mortality and morbidity. Dr Goodall urged Local Health Boards to consider bold clinical innovation and service configuration issued with the possibility of extended hours of access into evenings and weekends to increase capacity, particularly where treatments may have longer term benefits.

662. The Wales Cardiac Network (which forms part of the NHS Wales Health Collaborative comprising of leadership from the cardiac community and accountable to the Welsh Government) was also instrumental in requiring the restoration of cardiac services in Wales. I exhibit a letter sent from Dr Jonathan Goodfellow of the Wales Cardiac Network and a document entitled "Restoration of Cardiac Services" at **JPM3WGO02/326 INQ000469195** and **JPM3WGO02/327 – INQ000469191** respectively. These contained over-arching guiding principles for the restoration of cardiology services across Wales including: cardiologists being released from Covid/general internal medicine (GIM) rotas to return to cardiology work; cardiac specialist nurses being released from ITU and other high care areas to staff cath labs and resume specialist roles; cath labs and day units to returned to cardiology for use in diagnosis and treatment of cardiac patients; cardiac day patients being designated as green (Covid free) and ring-fenced to facilitate safe patient throughput.

663. On 22 March 2021, the Welsh Government published the Quality Statement for Heart Conditions which replaced the Heart Conditions Delivery Plan that was in place prior to the pandemic. This highlighted the immediate short-term focus on recovery and the medium- and longer-term potential for transform of cardiac services and set out 16 quality attributes of services for people with heart conditions in Wales. These focused on fostering an equitable, safe, effective, efficient and person-centred approach. I exhibit a copy of the Quality Statement at **JPM3WGO02/328 – INQ000469118**.

664. On 15 June 2021, the Welsh Government held a cardiac summit to understand the scale of the challenge facing cardiac services and agree key priorities and actions for restoring services across Wales. I have exhibited a report from the summit at **JPM3WGO02/329 – INQ000469212.** As set out in the report, these priorities were:

a) Work with the NHS and the third sector to continue to encourage the public to come forward to access cardiac services.

b) Getting the right blend of local plans and national directives – giving ourselves the permission to work differently and enabling services to make the changes.

c) Look at regional and national programmes to maximise access to cardiac diagnostics.

d) Local Health Boards should support and develop the workforce to adopt new ways of working.

e) Local Health Boards to continue to make use of a hybrid approach of face-to-face and virtual consultation in order to deliver services safely and in line with patient expectation.

f) Local Health Boards will collaborate on short-term and permanent service innovations that can shorten the cardiac diagnosis and treatment pathway.

g) The national leadership arrangements for cardiac services will respond to the vision set out in the National Clinical Framework and Quality Statement for heart conditions in order to support an immediate system focus on recovering pre-pandemic waiting list volumes and activity levels.

h) Development of an implementation plan for the Quality Statement for heart conditions to address longer term sustainability challenges facing cardiac services.

Guidance for the diagnosis, care and treatment of heart disease published during the relevant period

665. Earlier in this statement, I referred to the “Essential Service Guide on Cardiac Specialised Services” which was published by the Welsh Health Specialised Services Committee on 7 May 2020, and I exhibited earlier at **JPM3WGO02/324 – INQ000469211**. This set out a plan for cardiac services for the population of Wales and included clinical guidance on the prioritisation of cardiac services. A copy of the Guide was sent to the Welsh Government’s Essential Services Group for comment, but the Welsh Government was not responsible for the development of the guide.

666. The plan for cardiac services is set out Essential Service Guide on Cardiac Specialised Services. This represented a change from the usual practice in the delivery of heart services set out in the Heart Conditions Delivery Plan exhibited at **JPM3WGO02/330 - INQ000469878** which was place prior to the pandemic. The Heart Conditions Delivery Plan outlined the Welsh Government's commitment to both minimising the incidence of preventable heart disease and ensuring those affected by any kind of heart condition have timely access to high quality pathways of care, irrespective of where they live and whether these are delivered through hospitals or the community. However, the changes to the delivery of the services were required in view of the impact of the Covid-19 on the running of the health service.

667. I also referred to the "Restoration of Cardiac Services" earlier in this statement which was published by the Wales Cardiac Network and was exhibited at **JPM3WGO02/327 – INQ000469191.** This included guidance on clinical pathways for chest pain, structure heart disease, bradycardia/pacemaker, tachycardia, and heart failure. These were made in view of the aim to restore cardiac services and differed from the pathways in place prior to the Covid-19 pandemic due to the need for adherence to IPC measures such as limited exposure to different hospital areas and more stringent and regular cleaning protocols. Again, whilst the Welsh Government was provided with a copy of the guidance, the Welsh Government was not responsible for the development of the guide.

668. Further clinical guidance on the diagnosis, care and treatment of heart disease also continued to be given by NICE which provided a rapid guideline for acute myocardial injury dated 23 April 2020. However, again, the Welsh Government was not responsible for the development of that guideline.

Whether "stay at home, protect the NHS" public messaging deterred patients in Wales of heart disease from seeking treatment

669. Whilst not specific to patients in Wales with symptoms of heart disease, the Welsh Government's Essential Services Group found that there was evidence that people were not accessing services even with urgent and serious care needs due to a fear of catching Covid-19 and not wishing to be a burden on the NHS. This highlights the importance of public and staff messaging to minimise indirect harm.

670. I exhibit a report of the "Accessing Essential Services" campaign at **JPM3WGO02/332 - INQ000469297** which outlines the drop in the number of people accessing healthcare services. Reasons for the drop in accessing services include: people wrongly assuming hospitals and other health settings were only dealing with Covid-19; concerns that they are more at risk of contracting the virus in medical settings either because they are very vulnerable or because of the increased risk of infection in health settings; and delaying presenting for minor issues that can develop into more serious issues which will then need more resources to deal with at a later date. The public communications campaign which was launched by the Welsh Government to help tackle the problem of people not accessing services was aimed at communicating with the public that while services were different or being delivered by new or alternative methods that they were still available for those in need of urgent care. The key messages of the campaign were "*If it's urgent, don't wait, don't leave it too late*" and *"Our NHS services are available and we want those who need to seek care and treatment to continue to do so"*. These messages were issued via advertising media press releases, Welsh Government media briefings and social media channels.

Data relating to cardiac events during the relevant period

671. The Inquiry has asked for information on the monthly number of patients presenting at hospital with heart attacks or other cardiac events during the relevant period, and the monthly number in the three years prior to the Covid-19 pandemic.

672. The Welsh Government does not hold or collect any such data.

673. The Inquiry has asked me for information on the NHS cardiology waiting time targets in Wales.

674. Prior to the pandemic, the target waiting times for referral to treatment were set out in the Consolidated Rules for Managing Cardiac Referral to Treatment Waiting Times – March 2018 which I have exhibit at **JPM3WGO02/333 – INQ000469219.** The Welsh Government's policy on referral to treatment waiting times required that 95% of patients on a cardiac Referral to Treatment pathway will wait no longer than 26 weeks for treatment, and no patient will wait longer than 36 weeks. This is a combined target and is not broken down into component waits.

675. These referral to treatment times continued during the relevant period, but the Welsh Government was fully aware that the impact of the pandemic meant that waiting times far exceeded those targets.

676. I have provided below graphs showing the waiting times for those on the cardiology treatment pathway between March 2017 and July 2022:

Figure 14: Graph showing the patient pathways waiting at stage 4(1) of the cardiology treatment pathway

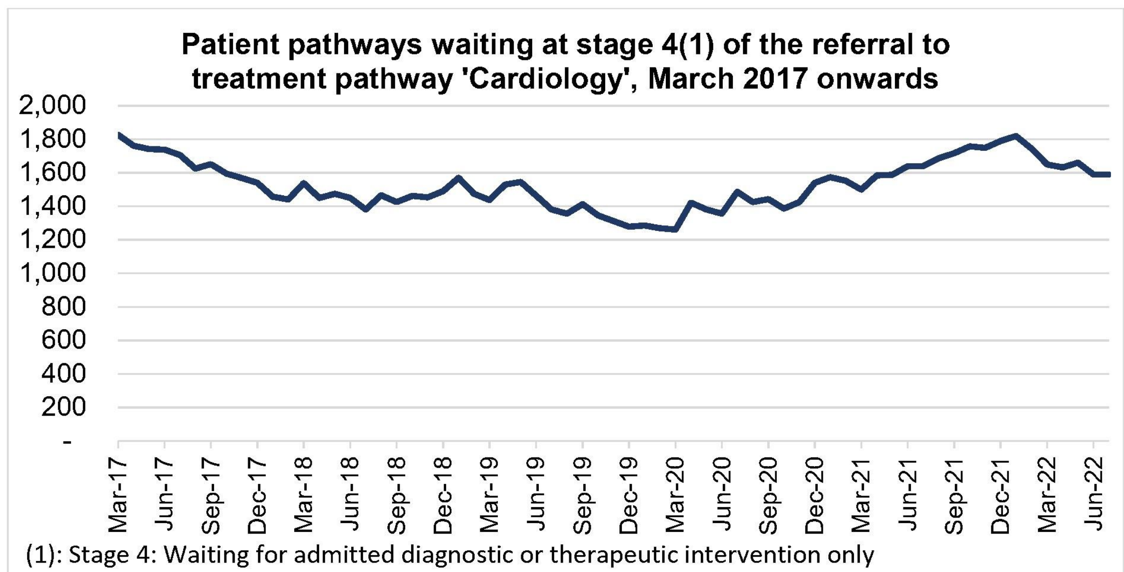


Figure 15: Graph showing the patient pathways waiting over 36 weeks at stage 4(1) of the cardiology treatment pathway

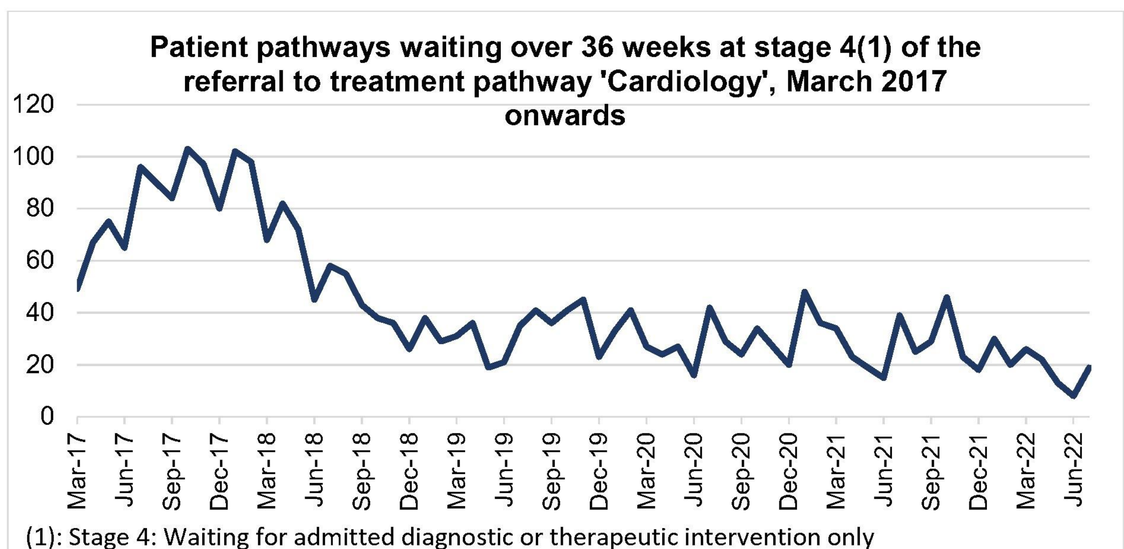
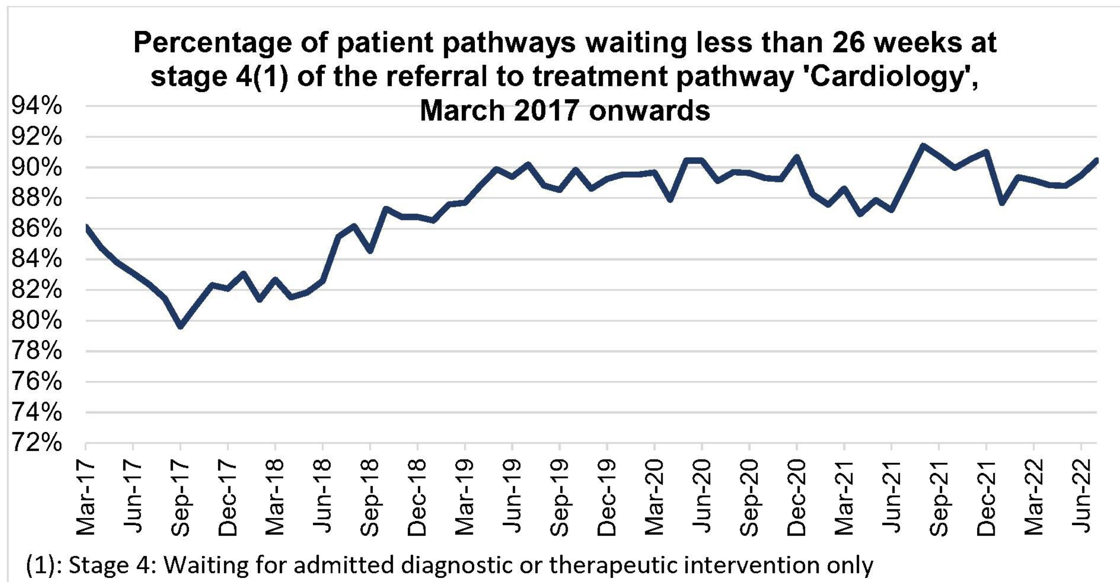


Figure 16 Graph showing the patient pathways waiting less than 26 weeks at stage 4(1) of the cardiology treatment pathway



677. I also exhibit an analysis report of the cardiology waiting times copy which was created by the Welsh Government in December 2022 at **JPM3WGO02/334 – INQ000469210**. This was presented at the UK Chief Medical Officer meeting of 15 December 2022 and indicated that the total number of waits (across all stages) for the cardiology pathway had increased at all Local Health Boards.

678. Work has been underway to improve waiting times as set out in "Transforming and Modernising Planned Care and Reducing NHS Waiting Lists" dated April 2022 which I exhibited earlier at **JPM3WGO02/306 – INQ000270477.** The plan lays out a number of key objectives to be achieved to reduce waiting times and transform service delivery:

a) Focusing on those with greatest clinical need: Clinical prioritisation of the waiting and supporting those who are waiting for treatment.

b) Increasing the capacity of the health service: Investing more in services, developing and expanding capacity, a focus on local service delivery, care closer to home where appropriate and regional centres to support high volume services.

c) Transform services to be sustainable for the longer term: Build a model that is both sustainable and able to meet the needs of future service plans.

679. It also highlights seven priorities to guide, support and influence recovery planning and investment decisions:

   a) Transformation of outpatients.
   b) Prioritisation of diagnostic services.
   c) Focus on early diagnosis and treatment of suspected cancer patients.
   d) Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities.
   e) Eliminating long waiters at all stages of the pathway.
   f) Build sustainable planned care capacity across the care pathway.
   g) The provision of appropriate information and support to people.

680. The Inquiry has asked for the number of surgical operations to treat heart disease undertaken during the relevant period. The Welsh Government does not hold or collect any such data. However, the Welsh Government is aware that during the first wave of the coronavirus pandemic virtually all cardiac surgery ceased apart from emergency cases.

681. The Inquiry has asked for the number and percentage of cancelled cardiac surgeries during the relevant period. The Welsh Government does not hold or collect any such data.

Impact of the pandemic on the capacity of the NHS in Wales to provide surgical treatments for patients with heart disease

682. Cardiac surgery was particularly impacted by the Covid-19 pandemic due to the high mortality risk if a patient contracted coronavirus. I exhibit the Essential Services Steering Group Review of Essential Cardiac Services dated 16 December 2020 exhibited at **JPM3WGO02/335 – INQ000399047.** This report outlined that there was a very significant reduction in cardiac surgery activity during the first wave of the pandemic due to the challenges faced relating directly to the coronavirus infection, either of staff or patients. Local action was taken to ensure safe access to cardiac surgery including a decision taken to move cardiac surgery out of University Hospital of Wales to University Hospital Llandough where there is no emergency department. However, as outlined in the report, the challenges posed by Covid-19 also led to a change in clinical pathways. For example, the treatment recommendations for valve

disease were that TAVI should be considered as an alternative to surgery in aortic stenosis. One of the key reasons for that being was that TAVI was a procedure that usually requires no ventilation or use of critical capacity.

683. I am also aware of a report prepared by the British Heart Foundation which summarised its findings on the impact of the pandemic on cardiac surgeries, which included a chapter on delays to surgical treatments, but this report was not specific to Wales. I exhibit a copy of the report at **JPM3WGO02/336 – INQ000469218.**

Impact of the pandemic on the capacity of the NHS in Wales to provide outpatient care for patients with heart disease

684. During the pandemic all Local Health Boards were encouraged to triage referrals for cardiology (at the point of referral) and to offer telephone and virtual appointments as well as face to face appointments if necessary.

685. I exhibit a copy of the summary of patient experience feedback on cardiac services at **JPM3WGO02/337 – INQ000469296** which includes some limited feedback on the use of telephone consultations. There were several positive comments made about telephone consultations which, when done well, provided patients with a good experience comparable to a face-to-face consultation.

Changes in the annual number of emergency admissions for patients requiring urgent treatment for a heart attack

686. The Welsh Government does not hold information on the annual number of emergency admissions in Wales for patients requiring urgent treatment for a heart attack compared to admissions in each of the three years preceding March 2020.

Private healthcare providers for the treatment and care for NHS patients in Wales with heart disease

687. Whilst private hospital capacity was commissioned on a national basis 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 Welsh Health Specialised Services Committee and its NHS partners. Whether the Local Health Boards utilised such private sector capacity in providing treatment and care for NHS patients in Wales with heart disease depended on their respective clinical needs. As such, the Welsh Government does not hold any detail on the number and

percentage of NHS patients' care and treatment for heart disease in this way or the percentage of these patients who received treatment within the target timeframes.

Impact of IPC measures in healthcare settings on care pathways for heart disease

688. The introduction of green and red zones allowed continued service provision and, in an attempt to keep patients away from acute sites with high levels of Covid-19, patients community venues were used as green diagnostic venues.

689. However, infection prevention and control measures had a significant impact on the ability to perform tests. There needed to be appropriate social isolation hence only single patients in waiting areas, following a test such as echo, the room had to be cleaned and the downtime is dependent on the number of air changes/hour in a room. Clearly these factors had significantly impacted capacity for investigations.

690. Guidance on Covid-19 precautions and particularly aerosol generating procedures and additional cleaning and other precautions also impacted on Local Health Boards' ability to provide a number of cardiac diagnostic tests. Alternative provision was provided where possible such as posting cardiac or drive-through facilities in some Local Health Board areas.

691. Local Health Boards would also determine their own logistical arrangements; for example, Cardiff and Vale University Health Board moved its cardiac surgery from the University Hospital of Wales to University Hospital Llandough.

Advice on the symptoms of Covid-19 for patients with heart conditions

692. Women who were pregnant with significant heart disease, congenital or acquired heart disease (such as heart failure) were clinically vulnerable and were therefore subject to the shielding advice that was given by the Welsh Government. Other than that, there was no specific direct advice given by the Welsh Government as regards the symptoms of Covid-19 for patients with heart conditions.

Child and Adolescent Mental Health Services

693. The Inquiry has asked me for information about child and adolescent mental health services ("CAMHS"). In order to address these questions, I have received support from Matt Downton (Deputy Director for Mental Health and Substance Misuse).

Overview of how CAMHS is commissioned and provided in Wales

694. NHS Mental Health Services for under 18s in Wales are commissioned by Local Health Boards in response to local needs. Service provision includes Local Primary Mental Health Support Services which are a requirement under the Mental Health (Wales) Measure 2010, specialist CAMHS, crisis services and Community Mental Health Teams.

695. Since 1 April 2024, the NHS Wales Joint Commissioning Committee is responsible for commissioning in-patient provision for CAMHS on behalf of the seven Local Health Boards. Prior to that date the responsibility fell to the Welsh Specialised Services Committee. Two Local Health Boards are commissioned by NHS Wales Joint Commissioning Committee to provide this service for Welsh residents: Cwm Taf Morgannwg University Health Board provides 15 beds for the South at Ty Llidiard and Betsi Cadwaldr University Health Board provides 12 beds at Abergele Hospital.

696. We only have low secure services in Wales. Young people requiring medium secure services are placed out of Wales. Very few young people require medium secure services and is only required when directed by the court or where a young person poses a serious risk to others. Only adults can be placed in high secure services.

697. In Wales, medium secure mental health in-patient services are commissioned on behalf of Local Health Boards by the NHS Wales Joint Commissioning Committee (previously Welsh Health Specialised Services Committee), either from NHS England or from the independent sector via the NHS Wales National Collaborative Frameworks. The National Collaborative Frameworks (Hospitals and Care Homes) were developed to enable:

    a) An approved directory of suitably qualified, financially viable providers to meet quality, service and cost criteria.

    b) The establishment of bespoke care standards, standard contract terms/conditions, and a transparent pricing framework.

    c) Consistent and sustainable high-quality service provision and improved patient/resident outcomes.

698. The National Collaborative Frameworks provide the enacting mechanism for the commissioning of services supported by the NHS Wales Quality Assurance Improvement Service (QAIS). The Framework is a formal agreement and mechanism developed together by the National Collaborative Commissioning Unit and NHS Wales Shared Services Partnership (Procurement team). These services are provided once a patient is placed through the National Collaborative Framework processes and an individual patient placement agreement is generated, and therefore a contract enacted, between the commissioner (Local Health Board or Welsh Health Specialised Services Committee, now the NHS Wales Joint Commissioning Committee) and provider.

Impact of the pandemic on the provision of CAMHS care

699. CAMHS services (both primary care and specialist CAMHS) were positioned as 'essential services' during the pandemic and a range of measures were put in place including additional investment, expanding support for low level mental health issues, and providing additional surge capacity. Overall, services remained open and accessible throughout the pandemic but with adapted service models. Referrals to specialist CAMHS remain higher than in pre-pandemic levels, along with higher acuity of presentations. Referrals to eating disorder services also increased during the pandemic but services report that referrals have since returned to normal levels.

700. During the first wave of the Covid-19 pandemic, the Essential Services Group, with wide representation from the Welsh Government and the NHS in Wales, oversaw the development and approval of an NHS Wales Essential Services Framework exhibited earlier in this statement, informed by World Health Organization guidance, which provided an agreed list of services deemed to be essential and a range of supporting guidance for the NHS in Wales. This included mental health.

701. A Mental Health Incident Group was also convened which included the Welsh Health Specialised Services Committee, the National Collaborative Commissioning Unit (Mental Health) and Health Inspectorate Wales. As part of the Mental Health Incident Group, a monitoring tool was developed to provide situation reports on capacity of mental health services. This showed data provided by individual Local Health Board mental health and CAMHS services, including in relation to local CAMHS services, specialist CAMHS services and CAMHS early intervention services. An example of the monitoring tool is exhibited in **JPM3WGO02/338 - INQ000239491.**

702. A mental health essential services framework was also developed to establish an assurance framework of priority functions essential to continue during the pandemic. It set out a table of different elements of mental health service provision and the essential functions which, if discontinued, could potentially lead to avoidable harm. Its aim was to establish markers whereby, if Local Health Boards and their partner local authorities were unable to sustain the specified level of service, they could raise concern in the situation reports. These could be used to consider any risk mitigation necessary and to consider the support required to sustain this level of service provision. The framework, entitled 'Essential Mental Health, Learning Disability and Substance Misuse Services during Covid 19 Epidemic', published on 6 May 2020, is exhibited in **JPM3WGO02/339 – INQ000469198**.

703. The frequency of reporting varied through the pandemic, with key issues being staffing, rising acuity/demand and in-patient beds. The Welsh Government response was to enable Local Health Boards to utilise service improvement funding flexibly to meet local needs and providing in-patient surge capacity.

704. The Together for Mental Health Delivery Plan 2019-22 was revised and re-published in response to Covid-19 and sets out strengthened cross-Government actions and actions that have been accelerated due to Covid-19. The plan is exhibited in **JPM3WGO02/340 – INQ000469295**. Alongside improving access to mental health support in schools, for CAMHS, this identified the following key priorities:

a) Improving access to support for the emotional and mental well-being of children and young people.
b) Improving access to support in the community for children and young people
c) Improving children and young people's mental health services.
d) Improving access to crisis and out of hours mental health services for children and young people, and
e) Improving the access, quality and range of psychological for therapies children and young people.

New referrals to CAMHs inpatient services

705. I have been asked to provide data on the number of new referrals to CAMHS or Child and Young Persons Mental Health Services ("CYPMHS") in Wales by month from March 2019 to June 2022. The Welsh Government only holds referral data for outpatient services, which is set out further below. For inpatient services, there are

not “referred in” as such as there is no waiting list; if people are assessed as needing inpatient services, then a bed/place is identified. The NHS Wales Joint Commissioning Committee would likely hold information on the relevant data on the numbers of patients requiring inpatients services during the relevant period.

706. The number of referrals for the first outpatient appointment for Child & Adolescent Psychiatry treatment function, by month and source of referral, are provided in the table below. The terms ‘initiated’ and ‘not initiated’ in this table refers to whether or not the referral was initiated by the consultant or independent nurse responsible for the outpatient episode. The Welsh Government does not hold data on the number of referrals by social workers, Youth Offending Teams, schools or other organisations.

Table 20: Number of referrals for the first outpatient appointment for Child and Adolescent Psychiatry

Referrals for the first outpatient appointment for the Child & Adolescent Psychiatry treatment function, by month and source of referral

Month	Initiated: Following a domiciliary visit	Initiated: Following an A&E attendance	Initiated: Following an emergency admission	Initiated: Other	Not initiated: Community Dental Service	Not initiated: General Dental Practitioner	Not initiated: Optometrists	Not initiated: Other source of referral	Not initiated: Referral from a Consultant or Independant Nurse, other than in an A&E department	Not initiated: Referral from an A&E department	Not initiated: Referral from General Medical Practitioner	Not initiated: Self-referral	Unknown Source of Referral	Grand Total
Mar-19			19	198				436	119	28	1092	18		1910
Apr-19				175				400	81	36	732	6		1430
May-19				188				521	93	28	687	9		1526
Jun-19				204				454	93	22	713	6		1492
Jul-19				165				514	104	14	779	7		1583
Aug-19				133				219	81	15	544	2		994
Sep-19				155				383	85	26	710	2		1361
Oct-19				216				518	105	41	1031	4		1915
Nov-19				214		1		461	104	28	824	1		1633
Dec-19				128				430	85	25	790	6		1464
Jan-20				193		1		418	91	24	894	6		1627
Feb-20				190				439	114	32	910	7		1692
Mar-20				162				489	92	33	789	3		1568
Apr-20				218				188	85	19	307	4		821
May-20				175				194	64	23	346	4		806
Jun-20				191				235	74	51	493	3		1047
Jul-20				208				301	96	46	597	9		1257
Aug-20				215				159	73	47	556	8		1058
Sep-20				301			1	382	82	58	754	2		1580
Oct-20			1	373				397	94	73	860	16		1814
Nov-20				333				412	100	64	850	16		1775
Dec-20				241		1		385	90	39	667	9		1432
Jan-21				284		1		257	84	50	578	12		1266
Feb-21				270				346	104	31	691	12		1454
Mar-21				314				422	118	58	878	16		1806
Apr-21			15	387				290	97	57	871	13		1730
May-21			1	363				383	91	50	988	1		1877
Jun-21			2	458				400	80	47	993	5		1985
Jul-21			15	309				404	98	41	815	4		1686
Aug-21			4	304				205	81	33	553	3		1183
Sep-21			13	312		1		355	91	39	873	4		1688
Oct-21			5	355				326	71	55	838	6		1656
Nov-21			2	410		2		401	91	73	975	6		1960
Dec-21				252				367	61	41	797			1518
Jan-22			1	359		4		277	55	66	859	1		1622
Feb-22			7	331		1		356	38	57	885	3		1678
Mar-22			8	400		3		544	85	59	1038	3		2140
Apr-22			5	277		1		319	60	63	751	1	3	1480
May-22			4	484		2		516	97	98	1076	12	11	2300
Jun-22			3	383		6		414	92	64	875	3		1840

Number of children referred but not accepted for inpatients treatment

707. I have been asked to provide the number of children referred who were not accepted for inpatient CAMHS/CYPMHS treatment each month during the relevant period. The Delivery and Performance Division within the Welsh Government received monthly CAMHS first appointment waiting times monitoring forms from each of the Local Health Boards during the relevant period. However, this did not include the number of children referred who were not accepted for inpatient CAMHS/CYPMHS treatment each month. This data is not held by the Welsh Government but by Local Health Boards.

Outline of changes in access to NHS urgent mental health support for children and young people in Wales during the relevant period

708. NHS mental health services were designated 'essential services' and continued to operate during the pandemic, though services did need to adapt service model. This adaptation was carried out at a Local Health Board level.

709. A rapid review of lessons learned from the changes to services was commissioned, dated August 2020 and is exhibited in **JPM3WGO02/341 – INQ000469217**. The report provides a breakdown of service changes made by individual Local Health Boards. Local Health Boards introduced local changes and technological solutions including telephone, video and online appointment, referral and advice services. The report noted that changes were made to create capacity and meet need in a different way due to the impact or restrictions of Covid-19. Because of the speed of response necessitated by the onset of the pandemic, and the unpredictable nature of how events might unfold, these changes were made at great speed and without the usual level of engagement and consultation that is often part of service change and development in the NHS and wider public sector. The report's overarching findings were as follows:

   a) "While the majority of changes made were accelerated service developments, rather than brand new innovation, there was significant anecdotal evidence of local improvements with potential for spread, in addition to the small number of genuine new developments which occurred solely as a consequence of the pandemic.

b) The combination of both new technology and new processes, while difficult to unpick, did enable teams to offer creative alternatives to service users in a way which sustained services wherever possible.

c) The sense of shared endeavour was consistent and strong but now required an equally strong and consistent response from organisations to ensure the long-term wellbeing of staff, especially if additional waves are anticipated.

d) Some of the changes implemented had a wider and often unintended and unexpected impact on the wider health and social care system – broadly resulting in improved relationships and more efficient use of resources by developing integrated solutions.

e) Many staff reported increased productivity and efficiency in their working lives as a result of reduced travel and less lengthy (and more accessible) meetings. Nonetheless this must be balanced against the increase in intensity also reported and the need for strategies to manage that.

f) The focus on the front end of clinical pathways (referral management, triage and assessment) exposed significant and inconsistent weaknesses in other parts of the pathway and systems that must be addressed if better clinical outcomes are to be achieved for those with lived experience.

g) The rapid roll out of digital solutions was broadly a success for many, but remains a risk for others where there are difficulties with connectivity and rurality – especially where those risks co-exist with poor or dated equipment and infrastructure.

h) Safeguarding was a consistent theme, in a variety of ways, which will need addressing in rolling out telehealth as an option for service delivery."

710. As noted in the Essential Services Group CAMHS Assurance Review paper, exhibited in **JPM3WGO02/342 - INQ000271699**, the Welsh Government undertook the following key actions to support CAMHS inpatient services during the relevant period:

a) Providing surge in-patient capacity and strengthening arrangements for patient flow: the Welsh Government provided additional funding for inpatient surge capacity to ensure mental health units, including for CAMHS, had flexibility to manage additional demands and any outbreaks on units. A 'bed management

panel' was also established including the NHS, Welsh Health Specialised Services Committee and the National Collaborative Commissioning Unit to support the flow of patients between in-patient and community settings. Further details of additional mental health and CAMHS funding is set out below.

b) Temporary modifications to the Mental Health Act: due to the potential increased demands on mental services, mental health provisions were included in the in the Coronavirus Act 2020 to amend the requirements set out in the Mental Health Act 1983. The temporary modifications aimed to ensure that people could still be admitted to hospital for treatment in order to prevent delays should mental health services be under unprecedented resource constraints due to the Coronavirus pandemic. Whilst the provisions were not commenced, they were seen as a necessary safeguard to ensure that mental health service could still operate effectively to meet patient needs.

c) Demand and capacity planning: The National Collaborative Commissioning Unit commissioned NHS Benchmarking Network to develop a demand and capacity toolkit for mental health and learning disability services. The toolkit aimed to support the NHS to plan given the impact of Covid-19. It used data from the Networks monthly report and provides a set of modelling tools to help examine how demand may change over time, supporting capacity planning. As set out in the table below, this provided an estimate of the likely changes in demand for mental health services, including CAMHS community services.

Table 21: Overview of mental health service demand

	Demand	Detail	Mitigating factors
Primary MH Care	• 40% increase **short/ medium term** • 20% increase **medium/ long** term	• Increase in people requiring psychological support or counselling for MH issues, psychosocial issues, staff trauma • Increase in people requiring assessment and short term innervations for deterring MH • Increase in people requiring MH support for long term physical health conditions including 'long Covid' • Increase in people requiring specific assessment such as dementia memory clinics and perinatal • Disrupted support services such as schools, family etc	• Employment support schemes(such as furlough) • Unemployment support • Substance misuse support • Housing support schemes • Homeless support • Support for Black Asian and Minority Ethnic communities • Perinatal support • Online support/third sector support
Community MH care	• 25% increase **short/ medium term** • 20% increase **medium/long** term	• Increase in people requiring assessment with newly presenting serious MH issues due to increase in MH risk • Increase in support required for known patients • Disrupted referral pathways such as primary care and emergency departments • Increase in acuity of new or known MH issues due to lack of early assessment or intervention	• Crisis support services • Online support • Substance misuse joined up working • Pathways back to primary care
Inpatients services	• 30% increase **short/ medium term** • 10% increase **medium/ long** term	• Longer lengths of stay due to lack of trial leave etc • Increase in patients requiring care • Increase in acuity due to lack of community support • Delayed discharges due to lack of community support/social care/ placements	• Alternatives to admission such as crisis sanctuaries • Home treatment services
CAMHS community	• 60% increase **short/ medium term** • 30% increase **medium/ long** term	• Increase in children requiring psychological support • Increase in children requiring CAMHS assessments • Increase in neurodevelopmental assessments	• School support • Parent/family support • Intensive community support • Resilient children's homes

		• Increase in acuity due to lack of normal community/school/family support	
Other general health services	• 10%-30% increase **short term**	• Increase in persons seeking advice from police/ambulance/emergency departments	• All the above • Pathways back to MH services/support • Local single point of access
Third sector	• Unknown	• Increase in persons seeking advice and support from third sector	• Joining up third and public sector support

Average wait times for children and young people referred to CAMHS/CYPMHS in Wales

711. I have been asked to provide data in respect of the average wait time for children and young people referred to CAMHS or CYPMHS during the relevant period. The Welsh Government does not hold data on average wait times.

712. The Welsh Government does collect and publish data on how many people aged under 18 waited more or less than 28 or 56 days from referral to a Local Primary Mental Health Support Service (LPMHSS) assessment. This is set out in first the table below. The second table below provides similar data in respect of under-18s waiting times for therapeutic intervention.

Table 22: Waiting times for a Local Primary Mental Health Support Services (LPMHSS) Assessment for under 18s

Waiting times for a Local Primary Mental Health Support Services (LPMHSS) Assessment for under 18s				
Month	**Number of patients who had waited up to and including 28 days from referral to a LPMHSS assessment**	**Number of patients who had waited over 28 days and up to and including 56 days from referral to a LPMHSS assessment**	**Number of patients who had waited over 56 days from referral to a LPMHSS assessment**	**Total number of LPMHSS assessments undertaken during the month**
Apr-20	270	138	88	496
May-20	234	84	57	375
Jun-20	294	24	64	382
Jul-20	325	25	22	372
Aug-20	280	44	7	331
Sep-20	276	44	12	332
Oct-20	331	98	15	444
Nov-20	293	190	19	502
Dec-20	249	131	25	405
Jan-21	219	134	63	416
Feb-21	231	73	94	398
Mar-21	259	98	59	416
Apr-21	204	154	68	426
May-21	210	134	83	427
Jun-21	250	195	84	529
Jul-21	235	159	194	588
Aug-21	211	155	164	530
Sep-21	237	94	226	557
Oct-21	284	112	174	570
Nov-21	388	166	113	667
Dec-21	298	100	108	506
Jan-22	284	146	199	629
Feb-22	283	109	152	544
Mar-22	342	136	139	617
Apr-22	217	108	152	477
May-22	397	90	251	738
Jun-22	310	99	208	617

Table 23: Waiting times from a Local Primary Mental Support Services (LPMHSS) Assessment to start of Therapeutic Intervention for under 18s

Waiting times from a Local Primary Mental Health Supoprt Services (LPMHSS) Assessment to start of Theraputic Intervention for under 18s

	Number of patients who had waited up to and including 28 days from a LPMHSS assessment to the start of a therapeutic intervention	Number of patients who had waited over 28 days and up to and including 56 days from a LPMHSS assessment to the start of a therapeutic intervention	Number of patients who had waited over 56 days from a LPMHSS assessment to the start of a therapeutic intervention	Total number of therapeutic interventions started during the month
April 2020	203	49	46	298
May 2020	171	22	26	219
June 2020	163	30	31	224
July 2020	211	27	46	284
August 2020	188	28	21	237
September 2020	162	29	11	202
October 2020	205	36	30	271
November 2020	229	31	29	289
December 2020	215	21	28	264
January 2021	230	35	47	312
February 2021	235	17	60	312
March 2021	272	22	44	338
April 2021	193	32	34	259
May 2021	180	23	64	267
June 2021	183	33	54	270
July 2021	160	41	63	264
August 2021	170	44	74	288
September 2021 (1)	140	67	81	288
October 2021	175	33	139	347
November 2021	216	57	110	383
December 2021	134	33	75	242
January 2022	157	69	140	366
February 2022	145	35	90	270
March 2022	208	62	121	391
April 2022	92	43	109	244
May 2022	153	59	135	347
June 2022	103	37	120	260

713. The same data as in the tables above is collected in respect of over-18s, but the Welsh Government does not hold specific data in respect of specific young adult age groups (such as 18 to 25 year olds).

714. The Welsh Government also collects and publishes data on how many children and young people had, at the time, been waiting for more or less than four weeks from referral to first specialist CAMHS (sCAMHS) appointment. The data for the relevant period is set out in the table below entitled 'Specialist CAMHS patient pathways waiting for a first appointment'. Specialist CAMHS services are for patients with greater complexity, severity and risk than those requiring primary care CAMHS services.

Table 24: Special CAMHS patient pathways waiting for a first appointment

Date	All		All
	Up to 4 weeks	Over 4 weeks	
March 2020	338	151	489
April 2020	196	191	387
May 2020	193	165	358
June 2020	256	104	360
July 2020	277	95	372
August 2020	269	99	368
September 2020	434	152	586
October 2020	482	301	783
November 2020	496	447	943
December 2020	398	537	935
January 2021	355	398	753
February 2021	339	238	577
March 2021	385	123	508
April 2021	336	198	534
May 2021	369	165	534
June 2021	382	280	662
July 2021	288	432	720
August 2021	270	510	780
September 2021	204	542	746
October 2021	210	544	754
November 2021	229	527	756
December 2021	156	549	705
January 2022	180	354	534
February 2022	221	329	550
March 2022	251	253	504
April 2022	178	254	432
May 2022	231	231	462
June 2022	202	250	452

715. Save as set out above, the Welsh Government does not hold data from the relevant period in respect of waiting times between referral to CAMHS or CYPMHS and first contact with outpatient or community support, or inpatient admission as a voluntary patient.

Waiting times for treatment by inpatient CAMHS/CYPMHS

716. I have been asked to provide an outline of the National Standards in Wales for waiting times for treatment by inpatient CAMHS/CYPMHS services. The Welsh Government

does not hold waiting times data relating to inpatient CAMHS/CYPMHS services. For inpatient services, there is no waiting time: if a person is assessed as requiring in-patient they are provided with a bed. If there are no beds available, the National Collaborative Commissioning Unit manages the National Framework to place individuals in suitable beds in the independent sector. All providers on the National Framework work to agreed standards and health boards will work to their local polices for the provision of inpatient care, in line with NICE guidance.

Number of children and young people compulsorily admitted to psychiatric inpatient care in Wales

717. I have been asked to provide data in respect of the number of children and young people compulsorily admitted to psychiatric inpatient care in Wales under the provisions of the Mental Health Act 1983 for assessment or treatment each month during the relevant period. These are known as 'formal' admissions. However, the Welsh Government does not collect data on the number of people admitted but on the number of admissions, nor was age data collected for compulsorily admitted patients for the time period requested. The data requested may be held by individual Local Health Boards.

Summary of guidance, directives or advice given during the relevant period regarding the provision of or access to inpatient CAMHS/CYPMHS

718. The following guidance relating to the provision of or access to mental health services, including CAMHS services, was produced by the Welsh Government during the relevant period:

    a) The 'Essential Mental Health, Learning Disability and Substance Misuse Services during Covid 19 Epidemic' framework exhibited above in **JPM3WGO02/339 – INQ000469198.** As set out above, this was an assurance framework of priority functions essential to continue during the pandemic, with a table of different elements of mental health service provision and the essential functions which, if discontinued, could potentially lead to avoidable harm.

    b) Guidance entitled 'Information note on delivering the Mental Health (Wales) Measure 2010 during Covid-19 pandemic; Guidance for local health boards and partners on mental health services during the COVID-19 pandemic' was published on 21 April 2020 and is exhibited in **JPM3WGO02/343–INQ000081036**. This noted the challenge for mental health providers to deliver

mental health service whilst also responding to Covid-19 public health advice. The guidance stated:

i. Organisational management of Covid-19 may require the redeployment of staff to cope with service pressures across the health and social care system. In mental health services, this redeployment and reconfiguration of who, how and where services are delivered may not necessarily align with what is currently stated in Local Health Board Part 1 Schemes or recognised as secondary mental health services.

ii. In order to deliver services and comply with public health advice such as social distancing and self-isolation, there are very likely to be situations that make it difficult for organisations and practitioners to follow the National Service Model for Local Primary Mental Health Support Services, codes of practice and any other associated code or guidance to their fullest. Practitioners should record any reasons or factors connected to Covid-19 that are impacting on how they are delivering services and service leaders should keep this impact under review.

iii. In recognition of these challenges, and the impact that they may have on how mental health services can be delivered, the Welsh Government:

    1. Suspended national data collection under the NHS Delivery on the Mental Health (Wales) Measure 2010 to reduce the burden of national reporting, although data should continue to be collected locally.

    2. Established a National Mental Health Collaborating Centre to pull together the latest guidance relating to the provision of mental health services and to provide a central point of contact, and to provide a platform to share good practice. This has a reporting link back into the Mental Health Incident Group.

c) Guidance for Local Health Boards and Independent Hospitals in Wales exercising Hospital Managers' discharge powers under the Mental Health Act 1983, published 21 April 2020 and exhibited in **JPM3WGO02/344-**

INQ000081030 with advice on conducting remote hospital manager panel hearings.

d) A letter to Local Health Boards and local authorities dated 1 February 2021 confirming that assessments under sections 11 and 12 of the Mental Health Act 1983 should not take place remotely, following a recent High Court decision. The letter is exhibited in **JPM3WGO02/345 – INQ000469087**.

b) Guidance for inpatients' leave from mental health or learning disability units during Covid-19, emphasising the need to comply with public health guidance and for those returning to the ward to take appropriate precautions and to isolate and follow the pathway for suspected cases if they develop symptoms. The guidance is exhibited in **JPM3WGO02/346 – INQ000270350[61].**

Impact of the pandemic on the provision of treatment for existing CAMHS/CYPMHS patients

719. I have been asked to provide data on the impact of the pandemic on the provision of treatment for existing inpatient CAMHS/CYPMHS patients, and in relation to the number of inpatient CAMHS/CYPMHS beds in Wales during the relevant period. The National Collaborative Commissioning Unit holds this data as the commissioner of these services. However, all inpatient units were adapted for IPC measures during the pandemic, and the Mental Health Incident Group did not receive any information or evidence to suggest that this impacted patient care. The key impacts on inpatient settings included changes to guidance on home leave and the potential for longer waits to identify a suitable placement for admission, but again there was no evidence reported to the Mental Health Incident Group to suggest that this impacted patient care. The availability of inpatient beds was mostly impacted by staffing issues and a bed management panel was established by the National Collaborative Commissioning Unit to support the flow of patients between community and inpatient settings. The panel met on a weekly basis.

Number of inpatient CAMHS/CYPMHS beds in Wales throughout the relevant period

720. The COVID-19 NHS beds data, which was collected and published throughout the pandemic, did not capture information on CAMHS specific beds as it excluded

[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 [INQ000469056]

paediatrics. The paediatric sitrep management information collected by Digital Health and Care Wales over this period only captured high level bed categories: paediatric critical care, other general acute paediatric beds and neonatal beds. Operational information about bed capacity was reported to the Mental Health Incident Group by the National Collaborative Commissioning Unit during the pandemic, but this information was not routinely reported to the Welsh Government.

721. The table below sets out the number of monthly available and occupied Child and Adolescent Psychiatry specialty beds during the relevant period. These beds were available to all Local Health Boards.

Table 25: Number of monthly available and occupied Child and Adolescent Psychiatry specialty beds

Monthly Welsh NHS beds data by measure for the Child and Adolescent Psychiatry specialty			
	Average daily available beds	Average daily occupied beds	Percentage occupancy
Mar-20	29	21.16	73.0
Apr-20	29.4	21.87	74.4
May-20	29	23.56	81.2
Jun-20	29.4	23.93	81.4
Jul-20	29	20.07	69.2
Aug-20	29.03	21.27	73.3
Sep-20	30	21.07	70.2
Oct-20	29.6	21.73	73.4
Nov-20	29.47	23.44	79.5
Dec-20	29.6	20.79	70.2
Jan-21	28.7	18.52	64.5
Feb-21	29	19.88	68.6
Mar-21	27.8	24.29	87.4
Apr-21	29	22.03	76.0
May-21	29	18.09	62.4
Jun-21	31.47	18.17	57.7
Jul-21	29.16	15.94	54.7
Aug-21	30.14	18.55	61.5
Sep-21	30.5	16.13	52.9
Oct-21	29.16	19.68	67.5
Nov-21	29.63	21.26	71.8
Dec-21	30.48	21.63	71.0
Jan-22	30.13	20.26	67.2
Feb-22	29.18	17.94	61.5
Mar-22	30.06	18.95	63.0
Apr-22	29.65	13.04	44.0
May-22	29.26	14.90	50.9
Jun-22	29.67	17.34	58.4

Staffing capacity for inpatient CAMHS/CYMPHS

722. The Mental Health Monitoring tool, referred to earlier in this statement, was developed to provide a level of assurance of capacity and capability during this period. This enabled Local Health Boards to report on their capacity to deliver essential mental health services during this time. The monitoring tool included both adults and CAMHS services. In addition to the high-level information reported in the

monitoring tool, Local Health Boards also established Covid-19 mental health leads (Adults and CAMHS) who met with officials on a weekly basis to provide assurance and further context to the information in the monitoring tool, including on any capacity issues. An example of the monitoring tool and matters raised by Local Health Board from December 2021, is produced below:

Figure 17: Example of the monitoring tool

NHS Wales Mental Health Status-December 2021

MH Status Matrix December 2021			ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	PTHB	SBUHB	All Wales Position	
Adults	Primary Care (LPCMHSS)	Referrals (number)	1,182	1,103	887	1,076	331	170	665	Total	5,414
		% assessed within 28 days *(Target 80%)*	89%	71%	89%	23%	93%	94%	98%	Average	80%
		Number waiting over 28 days *(Target 0)*	60	158	40	145	10	8	4	Total	425
		Number waiting over 56 days *(Target 0)*	1	115	3	215	1	0	1	Total	336
	Inpatient	Bed occupancy rates *(85% recommended for + flow)*	84%	88%	100%	100%	100%	93%	94%	Average	94%
		length of stay *(32 days is UK average)*	17.2	29.1	41	33.9	35	26	55.3	Average	34
		MHA admissions *(50% is UK average)*	24%	17%	22%	35%	18%	63%	39%	Average	31%
	CRHTT	Number of Referrals	229		380	211	217	50	100	Total	1187
		Number of Referrals Assessed	229		360	159	210	41	100	Total	1099
		% Referrals Assessed *(95% Target)*	100%		95%	75%	97%	82%	100%	Average	91%
	Adult & OPMH CMHTs (per 100k pop)	Referrals	507	521	199	357		515	113	Total	2,212
		Caseload (1700 is UK average)	2219	1478	561	1082		3881	564	Average	1631
Adults & OPMH	OPMH Inpatient	Bed occupancy rates (85% recommended for +flow)	71%	90.0%	99%	75%	90%	98%	80%	Average	86%
		MHA admissions *(50% is UK average)*	55%	40%	29%	75%	50%	50%	73%	Average	53%
CYP	CYP Primary Care (LPCMHSS)	Referrals (number)	124	213	177	231	64	59	104	Total	972
		% assessed within 28 days *(Target 80%)*	94%	38%	33%	60%	9%	92%	65%	Average	56%
		Number waiting over 28 days *(Target 0)*	5	11	44	23	17	2	6	Total	108
		Number waiting over 56 days *(Target 0)*	0	60	47	18	13	1	3	Total	142
	CYP Community (per 100k pop)	Referrals	268	557	331	545		247	294	Total	2242
		Caseload *(1645 is UK average)*	1,007		1,328	3,180		2,704	990	Average	1842
All MH	Vacancies (in Whole Time Equivalents)	Registered Nursing Vacancies	-55.50	-137.13	-113.92	-75.33	-87.00		-71.50	Total	-540
		Support Nursing Vacancies	-17.47	-56.91	-41.43	-10.55	-24.00		-38.52	Total	-189
		Psychiatrist Vacancies	-7.00		-18.42		-24.50		-17.48	Total	-67
		Psychologist Vacancies		-11.26	-24.90	-22.79	-15.00		-2.23	Total	-76

INQ000486014_0263

Figure 18: Example of matters raised

NHS Wales Mental Health Status-December 2021

MH General managers and CYP Leads	ABUHB	BCUHB	CTMUHB	CVUHB	HDUHB	PTHB	SBUHB
Current stood down services	None	None	None	None	None	None	None
Summary of service pressures/concerns	• Services remain fragile due to a combination of acuity/demand, • If situation worsens focus will be on urgent mental health care. • Local Choices Framework options could be stopping recovery "catch up activity", temporarily suspending some services such as Memory Assessment Services, suspending work around key strategic developments • Significant recruitment issues (particularly in-patient nursing and medical) • emotional well-being, resilience and morale of staff, (particularly inpatient nursing staff)	• Staffing availability & wellbeing • Management of Covid within in-patients • Take up of staff vaccinations. • Patient flow. • Impact on community patients if any reduction in support. • Partner decisions that have negative impact on integrated approach.	No response	• HB has identified which resources can be used to maintain the integrity of community services while ensuring a phased plan to support inpatients in the event of severe staffing shortages. • HB will continue red zone provisions for adult and older people • HB will, if required increase the use of out of area beds	• Impact on CAMHS if Paediatrics step away from community clinical functions • Demands upon SCAMHS will further increase with the predictable furth er increase in long waiting lists • CYP with ADHD / ASD / LD that require meds reviews will be delayed, resulting in increased fragility of community placements. • LA retracting community provision and f2f accessibility	• Reviewing Plans but no plans to stand down services	• Reviewing Plans but no plans to stand down services
HB request of National Support	Reconsider strategic priorities; consider review of leave guidance; national guidance on F2F v digital appointments; group work guidance; reconsider performance/oversight ask.						

723. One of the direct actions was the creation of a bed management panel which was also established and met on a weekly basis. This included the NHS, the Welsh Health Specialised Services Committee and the National Collaborative Commissioning Unit to support the flow of patients between in-patient and community settings. The Welsh Government also provided third sector recovery funding to ensure easy to access mental health support remained available to take pressure off NHS Mental Health Services. This included the CALL Mental Health Line and the rollout of online cognitive behavioural therapy.

Funds provided during the relevant period for NHS CAMHS/CYPMHS services

724. On 7 April 2020, the Welsh Government gave approval to spend up to £6m to purchase mental health inpatient capacity for adults or children and young people services (as required). The decision was based on the need to ensure services had flexibility to respond to the pandemic, recognising the restrictions put in place and the potential need to move mental health inpatients to isolate or cohort symptomatic patients, as noted in the Ministerial Advice exhibited in **JPM3WGO02/347–INQ000136777.** £2.2m of this funding was utilised in 2020-21. The Welsh Government does not hold any details as to how much of the funding was ultimately spent on CAMHS.

725. Within routine funding Ministerial Advice for 2019/20 mental health funding, £7m was provided in service improvement funding to health boards to support specific service improvement areas outlined within the Together for Mental Health Delivery Plan 2019-2022, as exhibited **JPM3WGO02/348– INQ000469075.** The intention of this funding was for it to be released subject to plans being approved directly with officials. However, due to the need to respond to Covid-19 pressures, officials originally provided the equivalent of six months funding (£3.5m), so as to enable services to have local flexibility in demand. We confirmed to health boards in August 2020 that the second half would be released following receipt of proposals against priority areas, which was done, acknowledging that there was still flexibility in managing the impacts associated with the pandemic for those initial months. This funding was subsequently included within their ring fence and is now part of their core allocation. It was therefore up to the individual health boards to decide how much of this funding to allocate to CAMHS inpatient services. If the Inquiry seeks a breakdown of each Local Health Board's expenditure, this should be requested from Local Health Boards directly.

726. On 8 September 2020, £1.3m of further funding was announced for national tier 0/1 support to relieve pressure from the NHS Services. This included strengthening support for lower-level mental health issues, for instance by extending the support offered by our CALL mental health listening and advice line. For CAMHS, this included extending online Cognitive Behavioural Therapy (16+), developing a Young Persons Mental Health toolkit hosted on the HWB (health and well-being) website, extending schools counselling services to strengthen the digital offer and strengthening support in schools.

727. To continue to support the recovery of mental health services, an additional £42m was approved for 2021-22 as part of the broader Welsh Government budget, some of which was utilised as cost pressure funding for health boards mental health services. This also included an additional £5.4m for CAMHS services and £4m to support the roll-out of the CAMHS schools in-reach pilots, approved on 22 February 2021.

Reports commissioned by or on behalf of the Welsh Government regarding the provision of CAMHS and other mental health services

728. As described in detail above, a rapid review of lessons learned from the changes to services was commissioned and published in August 2020, as previously exhibited in **JPM3WGO02/341 – INQ000469217**. The report's findings are set out earlier in this section.

729. The Essential Services Group CAMHS Assurance Review paper, exhibited earlier in **JPM3WGO02/342 - INQ000271699** identified the following lessons learned:

a) Lack of mental health integration: A key lesson is the urgent need to embed and integrate mental health within the wider NHS system and the Health and Social Services Group. Whilst the arrangements established to ensure the continuity and availability of NHS mental health services during the pandemic were effective, these arrangements operated alongside and felt more separate from the central NHS Governance arrangements that were established. An example is identifying the need for and process to secure surge in-patient capacity. This work was not included as part of the central mechanism to plan and assure the capacity of broader NHS services and needed to be undertaken separately. In all aspects of Covid planning and assurance there were separate arrangements for mental health which created additional challenges and the

potential for inconsistency when compared to the arrangement for 'physical health services'.

a) Digital: An early assumption was that a higher proportion of children and young people would engage with digital services when compared with adults. Based on anecdotal evidence from services this was not the case and further work is needed to understand the challenges and solutions. Local Health Boards would also have benefited from earlier guidance on the delivery of group interventions via digital means, including clear guidance on the appropriate digital platforms to use.

Long Covid

730. The Inquiry has asked me for information about long covid. In order to address these questions, I have received support from Professor Chris Jones (Deputy Chief Medical Officer for Wales).

Research commissioned into long Covid

731. The Inquiry has asked me to outline any research commissioned by the Welsh Government into the condition known as long Covid.

732. In March 2021, the Welsh Government invested £3m into the creation of a Wales Covid-19 Evidence Centre as outlined in the press release at **JPM3WGO02/349 - INQ000469059**. The Wales Covid-19 Evidence Centre formed part of Health and Care Research Wales, which is a networked organisation responsible for promoting research into diseases, treatments, services and outcomes (including research relating to Covid-19) and is accountable to the Minister for Health and Social Services. The aim of the Wales Covid-19 Evidence Centre was to synthesise and mobilise knowledge from research relating to Covid-19 to help inform Welsh policy and practice. The Wales Covid-19 Evidence Centre's work programme identified the most important Covid-related evidence needs and priorities in Wales, which included research in relation to long Covid. This was informed by evidence review work undertaken by the Welsh Government's Technical Advisory Group (TAG), which had identified a need for further research in relation to long Covid in its paper '"Long-COVID" – what do we know and what do we need to know?' exhibited at **JPM3WGO02/350 - INQ000350221**. This TAG report concluded that emerging findings across organ systems suggested that the diagnosis, treatment and

prevention of 'post-COVID-19 syndrome' (long Covid) would require integrated, multidisciplinary care pathways rather than organ- or disease-specific approaches.

733. The Wales Covid-19 Evidence Centre's work programme was also informed by consultation with key stakeholders involved in health and social care across Wales, including the Welsh Government. I have exhibited a list of research questions relating to long Covid that were prepared by the Welsh Government's long Covid subgroup and submitted to the Wales Covid-19 Evidence Centre in March 2021 for the purposes of developing its work programme at **JPM3WGO02/351 – INQ000469225.** This included what is the anticipated demand for long Covid services in Wales and what proportion of long covid patients are likely to require formal health and social care services, and what is the effectiveness of different forms of clinical intervention on supporting people with long Covid.

734. The Welsh Government's long Covid subgroup (originally called the Post Covid Syndrome Sub-Group but renamed in January 2021) was established on 24 November 2020 was responsible for overseeing a strategic approach to evidence-based health and care service development but did not oversee the strategic approach to research which remained with TAG and Health and Care Research Wales. I exhibit a copy of the terms of reference for the long Covid subgroup **JPM3WGO02/352 - INQ000469206.**

735. The reports published by Wales Covid-19 Evidence Centre in relation to long Covid include:

    a) 'Summary of Active and Prospective Long-COVID Research in Wales' dated November 2021 and exhibited in **JPM3WGO02/353 - INQ000350797.** This found that:

        i. The condition remains poorly understood and there is a need for further research.
        ii. Long Covid is used to describe a wide range of conditions. The causes are thought to be many and uncertain. There is no test for Long Covid and no treatment that can be clearly shown to have worked.
        iii. Long Covid affects both the individual and wider society as it can lead to inability to work and loss of productivity. As symptoms vary, patients need different investigations and treatments.
        iv. More research is needed so that local services can be provided according to need, and so that the treatments given can be based on

evidence of what works. Better understanding of the causes of long Covid will also help to avoid complications of the illness.

b) 'What is the cost impact of demands due to Long COVID on NHS and social care services?' dated April 2022' and exhibited in **JPM3WGO02/354 - INQ000469156.** This review found that there was no evidence found for the cost impact on social care services, and limited evidence of the cost impact of long COVID on the NHS:
   i. There is modelling that shows that quality adjusted life years (QALYs) are lost within 1 year of Covid-19 infection, most of which is due to Covid-19 symptoms and to a lesser extent permanent injury, and within 10 years, by this time it is projected to be almost equally due to Covid-19 symptoms and permanent injury.
   ii. People with long Covid may be financially impacted by experiencing a loss of income, loss of money through not being able to complete activities and an increase in health expenses.
   iii. Patient demand for long Covid health services is varied which will have a further impact on how care is provided and the cost effectiveness of that care.

c) 'What is the cost impact of Long COVID on employment and caring responsibilities?' dated May 2022 and exhibited in **JPM3WGO02/355 - INQ000469157**. This evidence summary concluded that there was very limited evidence found of the cost impact of long Covid on employment and caring responsibilities. One study reported that:
   i. Overall, 33.5% of respondents returned to work in the same capacity as before contracting acute Covid-19. 26.2% restarted on a part-time basis and 38% did not return to their job due to their health status after contracting acute COVID-19.
   ii. This percentage of people not returning to work due to their health status after contracting acute Covid-19 was higher amongst those that had been hospitalised with COVID-19.
   iii. Hospitalisation with Covid-19 meant a higher need for help with activities of daily living.
   iv. Duration of symptoms also meant a higher need for help with activities of daily living with those with a duration of symptoms over 6 months needing more frequent help.

v. Very limited support was provided by professional caregivers.
vi. 65% of support needs were met by informal caregivers.

d) 'What is the long-term impact of COVID-19 on the Health-Related Quality of Life of individuals with mild symptoms (or non-hospitalised): a rapid review' dated June 2022 and exhibited in **JPM3WGO02/356 - INQ000469881.** This suggested that Covid-19 infection may cause a reduction in 'health related quality of life' and impaired mental health (including anxiety and depression), even if the initial disease was 'mild'. The extent, severity, and duration of this was not clear.

e) 'What interventions or best practice are there to support with Long COVID, or similar post-viral conditions or conditions characterized by fatigue, to return to normal activities: a rapid review' dated January 2023 and exhibited in **JPM3WGO02/357 - INQ000469880**. This review's findings were as follows:
    i. Overall, the different sources of information indicated that a needs-based approach to care for people experiencing long Covid should be taken. Suggestions also include the need for people living with Long Covid to be accommodated in the workplace in the same way as people with disabilities.
    ii. There is some evidence to suggest that non-medication related interventions for Long Covid or Chronic Fatigue Syndrome (CFS) may help improve quality of life, but more research in this area would be needed to support this theory.
    iii. Long Covid fatigue can be managed in a number of ways, including exercise therapy, electrical nerve stimulation, and sleep and touch therapy. Writing behavioural self-management plans may be beneficial, especially when professional support is provided or delivered in groups.
    iv. One study investigated the benefits of a written self-management plan featuring active coping strategies for CFS in daily life. Following this intervention there was an 18% increase in the number of patients returning to employment having suffered with the condition.

f) Brain and Brainstem Basis of Long Covid (BBB-COV): Research Summary report dated August 2023 and exhibited in **JPM3WGO02/358 - INQ000469877.** This is a study designed to use a more powerful, specialised MRI scanner to

examine the brainstem of people with long Covid in more detail, to help to identify areas of the brain contributing to symptoms in long Covid.

736. In April 2023, the Wales Covid-19 Evidence Centre transitioned into the Health and Care Research Wales Evidence Centre which is funded by the Welsh Government for a period of 5 years. Whilst the scope of activity of the Health and Care Research Wales Evidence Centre has expanded to include research relating to a wider range of health and social care needs other than those relating to Covid-19, there remains a focus on research relating to Covid-19 and including long Covid. Welsh Government policy and professional officials, including those involved in the Welsh Government's Technical Advisory Group, continue to have regular engagement with the Health and Care Research Wales Evidence Centre and continue to inform its work programme.

737. As well as funding the establishment of the Wales Covid-19 Evidence Centre and the Health and Care Research Wales Evidence Centre, both of which have been instrumental in providing Welsh-specific research on long Covid, the Welsh Government has also participated in UK-wide research. This includes the UK Post-Hospitalisation Covid-19 Study which was funded by the National Institute for Health and Research and Medical Research Council UK Research and Innovation and led by the National Institute for Health and Care Research Leicester Biomedical Research Centre. This was a major UK wide study with sites in Wales, established to assess the long-term effects of Covid-19 on patients previously hospitalised with the virus and to help inform the development of care pathways. I have exhibited a written statement issued by the Minister for Health and Social Services on 22 October 2020 which announced Wales's participation in the UK Post-Hospitalisation Covid-19 Study at **JPM3WGO02/359 - INQ000412528**.

738. Health and Care Research Wales have also worked to support a coordinated UK research response to Covid-19 by actively promoting UK-wide Covid-19 funding calls such as the joint call by National Institute for Health and Care Research and UK Research and Innovation to fund research into longer term physical and mental effects of long Covid in non-hospitalised individuals. Health and Care Research Wales promoted the funding call through routine channels and networks to ensure that it reached the health and care research community in Wales and recommending for Welsh researchers to be on the assessment committers and as peer reviewers. Whilst Health and Care Research Wales does not run its own Covid-19 funding

scheme, the Welsh Government believes that participating in UK-level activity offers better coordination and portfolio oversight, makes effective use of quickly established and rapid turn-around processes, avoids potential research duplication and helps ensure that the most important, urgent and highest quality Covid-19 studies were funded.

Role of the Welsh Government in commissioning services in relation to long Covid

739. The Welsh Government recognised early in the pandemic that there would be a need for rehabilitation services for people who had been significantly affected by a Covid-19 infection. This is illustrated in the four nations statement dated 15 May 2020, which was issued prior to a recognition of 'long Covid' as a new condition and exhibited at **JPM3WGO02/360 - INQ000468981.**

740. The Welsh Government does not have a role in directly commissioning rehabilitation services required for people suffering with long Covid because the policy approach adopted by the Welsh Government has been that such rehabilitation services should be delivered at the local level as close to people's home as possible via existing primary and community care services. However, the Welsh Government has been instrumental in providing strategic direction and oversight to Local Health Boards in the delivery of those rehabilitation services within their respective local areas. I have exhibited earlier a written statement that was issued by the Minister for Health and Social Services Vaughan Gething on 23 October 2020 at **JPM3WGO02/359 - INQ000412528** which outlines the Welsh Government's policy approach to rehabilitation services for people recovering from long Covid, and also refers to resources that were published by the Welsh Government to support Local Health Boards to plan and develop its local rehabilitation services for those recovering from Covid-19. Such resources issued by the Welsh Government include:

   a) "Rehabilitation: a framework for continuity and recovery" which was a framework to help organisations plan rehabilitation services following the coronavirus pandemic. I have exhibited a copy of the framework published on 29 May 2020 at **JPM3WGO02/361 - INQ000369596.** The latest version of the framework is exhibited at **JPM3WGO02/362 – INQ000469231.** This sets out the 'WALES' principles of rehabilitation, organised around a central theme of person-centred care:

i. Wellbeing: investment in the workforce to provide a holistic person-centred, needs-based approach.
ii. Accessible: co-produced services that are equitable and inclusive to all.
iii. Living happier, healthier, longer: healthy living, prevention, supported self-management and optimisation.
iv. Everyone's business: a collaborative whole workforce and stakeholder ethos.
v. Sustainable: long term service planning, embracing digital innovation for societal benefit and greener ways of working and living.

b) "Rehabilitation needs for people affected by the impact of Covid-19" which was a guidance document published on 15 June 2020 to support practitioners and service providers to deliver appropriate and timely rehabilitation through a stepped care rehabilitation model to enable people affected by the impact of Covid-19 in Wales to return to their optimal level of independence and well-being. This includes detail on what people's specific rehabilitation needs are likely to be, those suffering from prolonged symptoms of Covid-19. I have exhibited a copy of "Rehabilitation needs of people affected by the impact of Covid-19" at **JPM3WGO02/363 - INQ000081238**.

c) "Rehabilitation: Post Covid-19 Evaluation Guidance" which was an evaluation guidance and a framework published on 7 July 2020 to support Local Health Boards, local authority and third sector services to understand demand for and evaluate the impact of rehabilitation in people affected by the Covid-19 pandemic, including those recovering from Covid-19. I have exhibited a copy of "Rehabilitation: Post Covid-19 Evaluation Guidance" at **JPM3WGO02/364 - INQ000469201**.

d) "Developing the Modelling Resource to understand the rehabilitation needs of people during, and following, the Covid-19 pandemic" published on 1 July 2020 and is a modelling resource guide all services to predict the demand for rehabilitation. I have exhibited a copy of "Developing the Modelling Resource to understand the rehabilitation needs of people during, and following, the Covid-19 pandemic" at **JPM3WGO02/365 - INQ000469046**.

741. In October 2020, the Welsh Government also issued a guidance document for primary and community care focusing on the rehabilitation needs of vulnerable

groups identified as having a higher risk of the impacts of Covid-19, including those with prolonged symptoms of Covid-19. I have exhibited a copy of "Primary and community care guidance for vulnerable groups identified as having a higher risk of the impacts of Covid-19" at **JPM3WGO02/366 - INQ000469053**. The guidance highlights the vulnerabilities associated with deprivation, obesity, age, comorbidities (such as dementia and Alzheimer's disease, cardiovascular disease, high blood pressure, respiratory disease, diabetes or kidney disease), occupation, ethnicity, and mental health.

742. The role of the Welsh Government in providing strategic direction and oversight in relation to services for long Covid is further demonstrated in correspondence sent by Dr Andrew Goodall to the Chief Executives of the Local Health Boards on 19 November 2020. This set out the Welsh Government's expectation that people with long Covid are able to access the majority of the services they need for assessment, diagnosis, treatment and rehabilitation support close to home, and only have to travel for more specialised services which have to be provided in an acute hospital setting. The letter also seeks information on each Local Health Board's local response and current and planned service provision. I have exhibited a copy of the correspondence at **JPM3WGO02/367 - INQ000469205.**

743. All Local Health Boards responded to the letter from Dr Andrew Goodall providing information on their local response and current and planned service provision. I exhibit the response of:

a) Cardiff and Vale University Health Board dated 2 December 2020 at **JPM3WGO02/367a - INQ000484895**.

b) Cwm Taf University Health Board dated 2 December 2020 at **JPM3WGO02/367b - INQ000484896.**

c) Powys Teaching Health Board dated 30 November 2020 at **JPM3WGO02/367c - INQ000484897**.

d) Swansea Bay University Health Board dated 3 December 2020 at **JPM3WGO02/367d - INQ000484898.**

e) Aneurin Bevan University Health Board dated 3 December 2020 at **JPM3WGO02/367e - INQ000484866.**

f) Hywel Dda University Health Board dated 4 December 2020 at **JPM3WGO02/367f - INQ000484900** and **JPM3WGO02/367g - INQ000484899.**

g) Betsi Cadwaladr University Health Board dated 11 December 2020 at **JPM3WGO02/367h - INQ000484901.**

744. By way of a summary of the responses received, all Local Health Boards confirmed that they had already started putting in place provision to support people with long Covid. All service development was led via primary and community care, and via Directors of Therapies and Health Science. All were community focused with a tiered approach to meet different levels of need, ranging from information and advice to self-care, supported self-care and rehabilitation, and referral pathways or access to secondary care. The likely need for increased resource to support service provision was raised by four organisations, and some suggested that additional investment from the Welsh Government would be needed.

745. In June 2021, the Welsh Government announced the launch of the "Adferiad (Recovery) Programme", which allocated £5 million to the seven Welsh Local Health for the period 2021/2022 to support the delivery of community led rehabilitation services (e.g. towards training costs, digital tools to aid diagnosis and primary and community infrastructure). This was initially allocated on a non-recurrent basis but a further £5m was allocated for the period 2022/23 to continue the development of Adferiad funded services. I have exhibited a policy and strategy document on the Adferiad (Recovery) programme dated 15 June 2021 at **JPM3WGO02/368 - INQ000412566**. This set out the steps taken by the Welsh Government in terms of investing in long Covid services, what patients can expect when accessing support from the Adferiad (Recovery) Programme, mental health and well-being for people with long Covid, how to support someone with long Covid and supporting NHS employees and other employers. I have also exhibited case studies on long Covid rehabilitation published on 1 July 2021 at **JPM3WGO02/369 – INQ000469226**. This includes a case study on a 53 year old female who works in the NHS in a non-patient role with long Covid, and a 55 year old male patient with no pre-existing conditions prior to contracting Covid-19, and sets out details of patient rehabilitation.

746. In March 2023, the Welsh Government increased the funding for the Adferiad (Recovery) Programme to £8.3m on a recurrent basis for 2023/24 onwards. This increase in funding is to ensure continued support for people with long Covid, and also to allow people suffering from other long-term conditions which have similar rehabilitation and recovery needs to those with long Covid such as Myalgic Encephalomyelitis (ME) and Chronic Fatigue Syndrome (CFS), to also access Afdferiad funded services. I have exhibited a written statement issued by the Minister for Health and Social Services, Eluned Morgan MS, on 14 March 2023 providing an update on the Adferiad (Recovery) Programme and the increase in funding at **JPM3WGO02/370 - INQ000412567**. As noted in the written statement, a review of the Adferiad (Funding) Programme confirmed that the Adferiad services are meeting the needs of people accessing them.

747. As set out above, the model adopted by the Welsh Government for long Covid services is that people with long Covid are able to access the majority of the services they need for assessment, diagnosis, treatment and rehabilitation support through existing primary and community care structures, with referral to more specialised services in an acute hospital setting for those people who need it. This model does not include the use of long Covid rehabilitation centres. This is because it was considered that in order to provide the level of support required in the community for those impacted by long Covid in Wales it was necessary to tailor care and support for people as close to their home as possible and to develop and invest in existing rehabilitation service delivered through primary and community care. This is consistent with the broader strategic direction for the NHS under a Healthier Wales and the Strategic Programme for Primary Care, and supports a broader transformation. It was also considered that the service model adopted in Wales would benefit a broader range of individuals who were suffering from other long-term conditions such as ME and CFS and not only those suffering from long Covid. I have exhibited a letter dated October 2021 from the Minister for Health and Social Services, Eluned Morgan, in response to a petition made by Jack Sargeant MS about opening one-stop medical hubs and clinics for people with long Covid at **JPM3WGO02/371 – INQ000469234.**

748. In developing the service model for long Covid, the Welsh Government draws from a range of resources including the overarching strategy documents such as A Healthier Wales, evidence from relevant research and consulting with key stakeholders in health and social care including patient support groups such as Long Covid Wales

with lived experience of long Covid. I have exhibited a letter sent from NR to Long Covid Wales dated 4 March 2021 outlining a meeting which took place on 16 February 2021 at **JPM3WGO02/372 – INQ000469224** at **JPM3WGO02/373 – INQ000469207**. Following these meetings Directors of Therapies and Health Science and lead practitioners continued to engage directly with people with lived experience of long Covid as they developed their specific service provision.

Involvement of the Welsh Government in formulating diagnostic tools, treatment protocols or clinical guidance in relation to long Covid

749. In addition to the documents issued by the Welsh Government to the NHS in relation to service provision for long Covid as set out above, the Welsh Government has also been involved in formulating clinical guidance, treatment protocols and digital tools in relation to long Covid.

750. Name Redacted (co-chair of the Covid-19 Rehabilitation Task and Finish Group) and Name Redacted (a member of the All-Wales Services Leaders Group) attended meetings with the National Institute for Health and Clinical Excellence (NICE) for the purposes of providing professional expertise into the development of clinical guidance for long Covid which was published on 18 December 2020. The guidance covers identifying, assessing and managing the long-term effects of Covid-19 and also establishes a clinical definition for long Covid.

751. On 22 February 2021, and in collaboration with the Local Health Boards, the Welsh Government circulated the "All Wales Community Pathway for Long COVID". This was later published on the Welsh Government website on 14 June 2021. I exhibit a copy of the most recent version of the All Wales Community Pathway for Long Covid at **JPM3WGO02/374 - INQ000412547**. In line with the NICE guidelines and A Healthier Wales, the Pathway provides clinical guidance on the management and treatment of long-Covid, including in what circumstances referral to more specialised services may be appropriate and details of the type of rehabilitation support which may be needed such as psychological support or fatigue and pain management. Whilst the services for long Covid are ultimately delivered at the local level in accordance with the needs of the relevant local area, the aim of the Pathway Is to inform and underpin local pathways to help to ensure a consistent approach is adopted across Local Health Board areas. I have exhibited a letter dated 22 February 2021 sent from Dr Andrew Goodall, who was, at that time, the NHS Wales Chief

Executive, to the Chief Executives of the Local Health Boards with details of the Pathway at **JPM3WGO02/375 - INQ000469096**.

752. To assist in ensuring consistency in the application of the Pathway, the Welsh Government commissioned the Institute of Clinical Science and Technology to produce a digital "guideline" called the "All Wales Guidelines for the Management of Long Covid" which provides health and care professional in primary and community care settings across Wales with a holistic and integrated suite of resources and training, enabling them to help and advise people recovering from long Covid. This includes the referral process into secondary care and clear guidance on when to arrange diagnostics for people living with long Covid. The purpose of the guideline is to ensure patients presenting with symptoms consistent with long Covid are offered effective quality care and support and in some cases referral to specialist support. The guideline was launched on 18 June 2021 and is accessed via the Institute of Clinical Science and Technology website. I have exhibited at **JPM3WGO02/376 - INQ000235884** a copy of the ministerial advice recommending approval for the All Wales Guidelines for the Management of Long Covid, for the reasons set out above.

753. Both the All-Wales Community Pathway for Long COVID and the All-Wales Guidelines for the Management of Long Covid promote the use of the NHS Wales Covid Recovery App which was launched on 20 January 2021. I have exhibited a press release dated 20 January 2021 outlining the launch of the NHS Wales Covid Recovery App in **JPM3WGO02/377 - INQ000469194**. The NHS Wales Covid Recovery App was commissioned by the NHS to support people experiencing the longer-term effects of coronavirus such as those suffering with long Covid, including enabling them to track their symptoms and progress and providing advice on managing their condition at home with support.

<u>Public Sector Equality Duty.</u>

754. The Inquiry has asked me for information about the public sector equality duty. In order to address these questions, I have received support from Dr Heather Payne (Senior Medical Officer for Maternal and Child Health), and Toby Mason (Head of Strategic Communications).

Impact of advice, policies or guidance in the health care system on specific groups

755. The ways in which the Welsh Government considered how changes to the delivery of healthcare services, and the advice, policies and guidance that it had input into, might impact upon groups protected by the Equality Act 2010, including the disabled, clinically vulnerable, ethnicity faith and belief, old and young, pregnancy and maternity, gender (including reassignment) and sexuality, and those with poor socio-economic backgrounds or those with existing health inequalities, as well as Welsh Language/Cymraeg is set out in paragraphs 221 to 261 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01). I will not repeat that information in this statement because the same remained the case during the relevant period that I was appointed Chief Executive of the NHS in Wales.

756. At paragraph 233 of the corporate statement of the Health and Social Services Group (reference M3-WGO-01), Dr Goodall provides details of the equality impact assessments that were undertaken during the relevant period and relate to the scope for Module 3. Further to that, I would like to bring the following equality impact assessments to the attention of the Inquiry:

a) **Winter Protection Plan 2020/21: Integrated Impact Assessment** (exhibited at **JPM3WGO02/381 - INQ000300275** This Winter Protection Plan covered the winter period 2020/21 but brought together the actions and developments since March 2020 including learning, innovation and new ways of working. The assessment found that the main impacts would be positive in that the Winter Plan was aimed at the whole population regardless of protected characteristics, but recognised that some groups or communities were at greater risk of being adversely affected by Covid-19. Where some people were identified to fall into a higher risk group, whether because of their underlying health conditions or their ethnicity, then the Winter Plan highlighted the need for organisations to consider and address these in the way in which they deliver their services, to promote equity of outcomes as far as possible.

b) **Impact assessment: Health and Social Care COVID-19 looking forward** (exhibited at – **JPM3WGO02/382 – INQ000469192).** In March 2021 the Welsh Government issued the Health and Social Care in Wales COVID-19: Looking Forward ('Looking Forward'). It set out the high-level expectations for NHS and social care recovery, the challenges and constraints and priorities for each part of

the system. The impact assessment identified opportunities taken to ensure fairness and equity had been adopted in the approach, however it also recognised the need to build on existing policies and approaches, rather than creating new ones. It emphasised that health and social care services needed to plan to meet the needs of their respective populations with due regard to Equality Act 2010 protected characteristics, to achieve equity of outcomes and protections according to risk. It made clear the need for organisations to ensure that individuals and communities have equal access to diagnosis and treatment, with regard to the four harms. It also recognised that some groups of people were at greater risk of adverse impacts from contracting Covid-19 infection, and reinforced the need for organisations to mitigate this, deploying the test, trace and protect arrangements that were geared to reducing the spread of Covid-19 and supporting effective, integrated vaccination programmes for higher risk groups, including pregnant mothers and children and young people, for influenza and Covid-19.

c) **Winter protection plan 2021 to 2022: integrated impact assessment** (exhibited at – **JPM3WGO02/383 – INQ000469200**). The Winter Plan is an integrated plan which set out how organisations working across the health and social care community would need to contribute in order that all services could deliver effective care to the people of Wales in winter and to provide a blueprint going forward. As with the preceding year, the assessment found that the main impacts would be positive in that the Winter Plan was aimed at all individuals and communities, but recognised that some, especially those with protected characteristics under the Equality Act 2010, especially combinations of risk factors ('intersectionality') were at greater risk of being adversely affected by Covid-19. The Winter Plan highlights the need for organisations to identify, address and mitigate these additional risk factors in the way in which they design and deliver their services, to promote equitable outcomes for all.

d) **Programme to transform planned care and reduce waiting times: integrated impact assessment** (exhibited at **JPM3WGO02/384 – INQ000469202)**. The plan to transform and modernise planned care, and reduce waiting lists in Wales was designed to combat the effect that Covid-19 had on services and waiting lists within the NHS. The assessment noted that people from disabled, ethnic minority communities, older people, children, and young people and those with learning disability or mental ill health felt an impact not only from Covid-19 but also from the restrictions that were imposed. It was important for us to put in place plans to allow

increases in capacity to respond to these needs. The plan recognised the need to review and treat those in most clinical need first, as well as recognising wider social needs.

Steps taken by the Welsh Government to ensure that health communications were accessible

757. The Inquiry asks about the steps taken by the Welsh Government to ensure that health communications during the relevant period were accessible to patients, service users, carers and parents with a disability, impairment or sensory loss, in accordance with the NHS Accessible Information Standard. This statement can describe action taken by or on behalf of the Welsh Government but cannot speak to communications prepared by Public Health Wales or the NHS in Wales.

758. Simultaneous British Sign Language translation was used at all press conferences throughout the pandemic. These were livestreamed on Welsh Government digital channels as well as broadcast live on BBC Wales.

759. In April 2020, The Health and Social Services (HSS) Communications Team worked with the Corporate Communications Team to review accessible communications in public facing marketing, which included a review of the UK Government, Public Health Wales and Welsh Government materials to ensure there was no duplication as well as accessibility.

760. At this time messaging changed frequently and could quickly be out of date, therefore the public information campaign (i.e. all communications issued including advertising, posters, press notices and social media) promoted the gov.wales/coronavirus website, which was updated regularly. The gov.wales/coronavirus website aimed to be fully accessible via screen-reader technology which "reads" documents out loud to people who are blind or have visual impairments. From April 2020, the site also allowed users to view content in different languages.

761. In order to make information on the Welsh Government website as accessible as possible to as many people as possible, the site enables users to change colours, contrast levels, text size and fonts to suit their needs by configuring their web browser accordingly. The website can zoom in up to 300% without the text spilling off the screen. Users can navigate most of the website using just a keyboard and most of the website can be navigated using speech recognition software. Most of the website can use a screen

reader. Users can also request information in a different format like plain text, braille, British Sign Language, large print, easy red or audio recording. The current accessibility statement was published in its current form in June 2020 set out in the form of a template provided by the UK Government Digital Service, but a light touch version of the accessibility statement was available prior to June 2020. There was an ongoing programme of work from November 2019 to make further incremental improvements to the site's accessibility and functions which aligned to a timetable set out by the UK Government Digital Service for public sector websites. Most accessibility functions such as responsive layout, zoom, keyboard-only navigation and assistive technology would have been in place and being improved.

762. In June 2020, the Local Government and Communities Communications team established the Welsh Government Accessible Communications Group. The Group consisted of a wide range of stakeholders such as Disability Wales, National Autistic Society Cymru, Wales Council for the Blind, Wales Council for Deaf People.

763. This group was consulted on and supported the development of the Welsh Government's Accessible Communications guidance, which was finalised in June 2021 and exhibited at **JPM3WGO02/386 - INQ000282164**, and explained how to make digital services, websites and apps accessible to everyone, including users with impairments to their:

    a) vision: like severely sight impaired (blind), sight impaired (partially sighted) or colour blind people;
    b) hearing: like people who are deaf or hard of hearing;
    c) mobility: like those who find it difficult to use a mouse or keyboard;
    d) thinking and understanding: like people with dyslexia, autism or learning difficulties.

764. During the summer of 2020, the Health and Social Services Communications team worked with the Head of Communications for Local Government and Communities to gather feedback on Keep Wales Safe and Test, Trace, Protect communications. The team shared assets via the Welsh Government Accessible Communications Group to ensure the campaigns were as accessible as possible. With the help of the group, messages were developed in multiple languages and formats, including British Sign Language, plain language and Easy Read, as well as more than 30 languages.

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.

Personal Data

Signed: ___________________________________

Dated: 04/06/2024