Witness Name: Eluned Morgan
Statement No.: M3 1
Exhibits: 164
Dated: 15 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ELUNED MORGAN

I, ELUNED MORGAN M.S., 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 dated 18 March 2024 and referenced M3/MEM/01.

Preface

2. The purpose of this statement is to assist the Inquiry to examine the impact of the Covid-19 pandemic on the healthcare system in Wales.

3. My response to the Inquiry's request for evidence made under Rule 9 of the Inquiry Rules 2006, referenced M3/MEM/01, relates to my specific involvement in decisions relating to the impact of the pandemic on the healthcare system in Wales during the period of time between 1 March 2020 and 28 June 2022 ("the relevant period"). I have drawn support from my office and officials in the Health and Social Services Group and from contemporaneous documents in preparing this statement.

4. The impact of the pandemic on the healthcare system in Wales was enormous. However, the incredible dedication and commitment of health workers and their professionalism meant that, not only did the system not become overwhelmed, but the rollout of the vaccination programme was UK- and world-leading. The legacy

of the pandemic however remains with us and the health service in Wales is still working exceptionally hard to clear the immense backlog of clinical interventions that built up during the pandemic.

5. The information I have provided in this statement is structured as follows:

    a. **Part A:** Personal Background
    b. **Part B:** Ministerial Role and Working Relationships
    c. **Part C:** Non-Covid-19 Treatments
    d. **Part D:** Increasing Capacity
    e. **Part E:** Infection Prevention and Control
    f. **Part F:** Shielding
    g. **Part G:** Other Matters
    h. **Part H:** Lessons Learned

Part A: Personal background

6. I studied European Studies at the University of Hull, following which I worked as a researcher for S4C, Agenda TV and the BBC. In 1990 I worked as a stagiaire in the European Parliament for the Socialist Group.

7. In 1994, I was elected as a member of the European Parliament, and I represented Wales for the Labour Party between 1994 and 2009. I served as the budget control spokesperson for the Socialist Group, and I was also the Labour Party's European spokesperson on Energy, Industry and Science. I was responsible for drafting the European Parliament's response to the Energy Green Paper and I also took the lead role in negotiating on behalf of the Parliament the revision of the Electricity Directive. I did not seek re-election at the 2009 European Parliament elections.

8. From late 2009 until July 2013, I was the Director of National Business Development in Wales for SSE (SWALEC). I was also appointed Chair of the Cardiff Business Partnership.

9. On 24 January 2011, I was granted a life peerage and would sit on the Labour benches of the House of Lords. I am formally known as Baroness Morgan of Ely. During 2013 to 2016, I served as the Shadow Minister for Wales in the House of

Lords, and from 2014 to 2016 as Shadow Minister for Foreign Affairs and also as a whip.

10. I served on the Welsh Labour Party Executive for ten years and was appointed to the Welsh Assembly Advisory Group which was responsible for developing the standing orders of the Senedd. I was a founding member of the Yes for Wales Cross-party group, which campaigned for the Assembly to be established.

11. In May 2016, I was elected to the National Assembly as regional member for Mid & West Wales.

12. I have held a number of ministerial positions within the Welsh Government:

    a. Minister for Welsh Language and Lifelong Learning: November 2017 to December 2018;
    b. Minister for International Relations and the Welsh Language: December 2018 to October 2020;
    c. Minister for Mental Health, Wellbeing and the Welsh Language: October 2020 to May 2021;
    d. Minister for Health and Social Services: May 2021 to March 2024;
    e. Cabinet Secretary for Health and Social Care: March 2024 to present.

Part B: Ministerial Role and Working Relationships

13. My role as a Minister changed considerably during the relevant period. As set out above, at the outset I was the Minister for International Relations and the Welsh Language. In October 2020, my role developed to meet the needs of the pandemic into the Minister for Mental Health, Wellbeing and the Welsh Language.

14. On 13 May 2021, following the Senedd elections, I succeeded Vaughan Gething as Minister for Health and Social Services. During the period 13 May 2021 to the end of the relevant period, my responsibilities as Minister for Health and Social Services were:

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

- NHS delivery and performance;
- Escalation procedures;
- Receipt of, response to, and direction of reports from Health Inspectorate Wales;
- Oversight of the Welsh Government's relationship with Audit Wales regarding activities relating to the NHS;
- Medical workforce training and development (with the exception of years 1-5 of University Education for Doctors);
- Research and development in health and social care;
- Health innovation and Digital;
- Mental health services;
- Suicide prevention;
- Dementia;
- Autism;
- Health impact of problem gambling;
- Substance misuse;
- Armed Forces and Veterans' health;
- Public Health: Health improvement and wellbeing services;
- Obesity strategy;
- Food Standards Agency in Wales, including food safety;
- Genetically-modified food (but not genetically-modified crops);
- Patient experience, involvement and the citizen's voice;

- Safeguarding;
- Adoption and fostering services;
- Children and young people's advocacy including complaints, representations and advocacy under the Social Services and Well-being (Wales) Act 2014;
- Information sharing under the Children Act 2004 Cafcass Cymru;
- Policy and oversight of the provision of all social service activities of Local Authorities in Wales, including the issue of statutory guidance;
- Oversight of Social Care Wales;
- Regulation of residential, domiciliary, adult placements, foster care, under 8's care provision and private healthcare;
- Inspection of, and reporting on, the provision of social services by Local Authorities (via Care Inspectorate Wales), including joint reviews of social services and responding to reports;
- Children's and young people's rights and entitlements, including the UN Convention on the Rights of the Child;
- Early years, childcare and play, including the Childcare offer and workforce;
- Early childhood education and care;
- Flying Start for children 0-3;
- Families First and play policies.

15. As the Minister for Health and Social Services I am responsible for exercising relevant powers and making decisions on areas within my portfolio as outlined above, including the healthcare system in Wales. This involves setting policy and standards to promote high quality, safe health and care services based on

population need, determining the strategic distribution of overall NHS resources and holding NHS leaders to account. During a health emergency, the Minister for Health and Social Services is also responsible for the preparedness of the NHS and the health sector, NHS capacity and ability to increase capacity and resilience. The first year of my appointment as Minister for Health and Social Services was overwhelmingly taken up with the Covid-19 response and the impact on the NHS.

16. In undertaking the role of Minister for Health and Social Services, I work closely with the Welsh Government's Health and Social Services Group ("the HSSG") which is led by a senior civil servant who holds the dual role of Director General of the Health and Social Services Group and Chief Executive of NHS Wales. The dual role was held by Dr Andrew Goodall from June 2014 to November 2021, and by Judith Paget on a temporary basis from November 2021, and a permanent basis from 1 June 2023, to present. In practice, this dual role enables a very close working relationship between the Minister for Health and Social Services and the NHS in Wales. I also work very closely with other Welsh Government officials such as the Chief Medical Officer for Wales and the Chief Nursing Officer for Wales.

17. Supporting me as Minister for Health and Social Services during the relevant period was the Deputy Minister for Health and Social Services, a role that was held by Julie Morgan MS. I delegated the following responsibilities to her accordingly:

    a. Safeguarding, adoption and fostering, children and young people's advocacy including, complaints, representations and advocacy under the Social Services and Wellbeing (Wales) Act 2014, Information sharing under the Children Act 2004, CAFCASS Cymru.

    b. Children and young people's rights and entitlements including the UN Convention on the Rights of the Child, early years childcare and play including the childcare offer and workforce, early childhood education and care, Flying Start, Families First and play policies.

c. Policy and oversight of the provision of social services activities of local authorities in Wales, including statutory guidance, oversight of Social Care Wales.

d. Regulation of residential, domiciliary, adult placements, inspection of and reporting on the provision of social services by local authorities (via Care Inspectorate Wales) including joint reviews of social services and responding to reports.

18. In addition, Lynne Neagle, MS held the role of Deputy Minister for Mental Health and Well-being from the 13 May 2021 to the end of the relevant period. I delegated the following responsibilities to her:

a. Mental health services;
b. Suicide prevention;
c. Dementia;
d. Autism;
e. Health impact of problem gambling;
f. Substance misuse;
g. Armed Forces and Veterans' Health;
h. Health improvement and wellbeing services ;
i. Obesity strategy;
j. Food Standards Agency in Wales, including food safety;
k. Genetically-modified food (but not genetically-modified crops);
l. Patient experience, involvement and the citizen's voice.

19. I am aware that Dr Andrew Goodall has provided a statement to the Inquiry (M3/WGO/01) in which he has explained at paragraphs 16 to 20 the legislative background to the NHS in Wales and, for that reason, I will not repeat that here.

20. I further understand that the First Minister, Vaughan Gething, has provided a statement to the Inquiry and, at paragraphs 26 to 32, has outlined the role of the Minister for Health and Social Services (which he held from 2016 until 13 May 2021). In particular, I understand he has confirmed to the Inquiry the extent of the

responsibility that this position holds for strategic, as opposed to operational, decision-making in relation to the NHS healthcare system in Wales. I will not reiterate this but will provide my reflections on the role noting that, by the time of my appointment in May 2021, there was an established order for decision-making in relation to Covid-19 and its impact on the NHS healthcare system.

21. As a matter of fundamental principle, the position remained that the Minister for Health and Social Services continued to be responsible for strategic decision making and policy making in relation to health, and delegated the responsibility for day-to-day operational work to Local Health Boards and NHS Trusts. However, there was an increase in the intensity of strategic oversight and co-ordination required to ensure that NHS bodies were supported in responding to the pandemic and continuing to deliver health services. The details of this have been set out in the statement of Vaughan Gething and, where relevant to matters arising during my tenure, throughout this statement. By comparison, when it came to the vaccination roll out there was much more centralised control, and a system in place which knew where every vial of the vaccine was in the country. A policy decision on putting significantly additional resource into long Covid for example was determined at a national level but rolled out at a local level with clear monitoring so that lessons could be learnt from different approaches across the country.

22. The Inquiry has also asked whether I consider that the Welsh Government was well-equipped to take on operational responsibilities. As already noted above, the Welsh Government's responsibilities were strategic, not operational.

Decision making relating to the healthcare system in Wales

23. The Inquiry has asked me to provide an explanation of how I made and implemented decisions relating to the NHS healthcare system in Wales, including the relationship between the Minister for Health and Social Services and the Health and Social Services Group, and the mechanisms for liaising with other Welsh Government colleagues, advisers or organisations, UK Government departments or bodies and non-government organisations.

24. As set out earlier in this statement, the NHS fell within the scope of my portfolio as Minister for Health and Social Services during the relevant period following my appointment in May 2021 and I was therefore responsible for making strategic decisions regarding the healthcare system in Wales. The main route by which Ministers make decisions relevant to their portfolio is via the Ministerial Advice process. A Ministerial Advice is a document submitted by civil servants to a Minister which provides formal advice relating to a new decision, policy, legislation or anything else upon which a Minister is invited to make a decision.

25. In making decisions relating to the healthcare system under the Ministerial Advice process, the primary source of my policy advice would come from officials within the Health and Social Services Group. This is made up of experienced civil servants who work closely with the NHS bodies in Wales. For example, when clinical advice was required, either the Chief Medical Officer for Wales or the Chief Nursing Officer for Wales would feed into the Ministerial Advice process. When making decisions relating to the healthcare system, if I did not feel that I had sufficient information as part of a Ministerial Advice to enable me to make a decision, I would not hesitate in meeting with the relevant officials to discuss the advice and to ask for further information if required.

26. Generally, once a substantive decision was made upon a Ministerial Advice, a decision report was published on the Welsh Government's website providing a short summary of the issue and the Minister's response to a recommendation.

27. I exhibit a table at **M3MEM01/001 - INQ000480090** listing the relevant Ministerial Advice submitted to me either for a decision or to note during my tenure as Minister for Health and Social Services during the relevant period.

28. Implementation of any decisions made would be the responsibility of my officials in the Health and Social Services Group (for example, if the decision related to funding then the necessary arrangements would be made by the financial team) or it would be the responsibility of the Health Boards if the decision related to the delivery of services. Implementation by the Health Boards would be overseen by the Chief Executive

Officer of the Health Board and usually built into the Health Board's Integrated Medium Term Plans.

29. The Chief Executive Officers of the Health Boards would report to the Director General of the Health and Social Services Group. Once more, I am aware that the nature and extent of this role has been set out in the statements of Andrew Goodall and the First Minister, Vaughan Gething and so I do not repeat those.

30. As already stated above, at the time of my appointment, there were established working practices in place (which have been outlined by my predecessor, Vaughan Gething) and which I continued in my role. Accordingly, I met with the Director General on a weekly basis. There was a change in appointment to that role during my tenure, but the meetings continued under both Andrew Goodall and then Judith Paget on the same basis.

31. Outside the Health and Social Services Group, a person with whom I had regular contact when making decisions relating to the healthcare system was my special advisor Clare Jenkins who would provide me with advice on political matters.

32. I would also liaise with Welsh Government Ministers at regular meetings such as Cabinet and meetings to update on Covid-19. These meetings were helpful in obtaining and sharing relevant information about wider aspects of the pandemic which I could draw from when considering strategic issues relating to the healthcare system.

33. Outside the Welsh Government, throughout my tenure as both the Minister for Mental Health, Wellbeing and the Welsh Language and the Minister for Health and Social Services I would also meet regularly with chairs and chief executives of NHS bodies to ensure that I was kept informed of what was happening "on the ground" in terms of the impact of the pandemic on the healthcare system, and what they needed by way of support. These were particularly helpful as, due to the ongoing concerns regarding the presence of Covid-19 in hospitals and the various restrictions in place to lower transmission, I was largely unable to visit clinical settings in the way someone in my role otherwise might, until later in my tenure as Minister for Health and Social Services.

34. I would also have regular meetings with the UK Government and the devolved nations which I describe in further detail below.

35. The role of Cabinet and my Ministerial colleagues is again set out by my predecessor, Vaughan Gething, at paragraphs 51 to 58 of his statement. The limited extent of decision-making by the Cabinet insofar as decisions relating to the healthcare system in Wales remained true as at the time of my appointment. Whilst many of the substantial and significant decisions relating to the pandemic response would be made collectively by Cabinet, rather than on an individual ministerial basis, these related to decisions which raised significant issues of policy or were of critical importance to the public. Examples include decisions about lockdowns, social distancing, the use of face coverings and other non-pharmaceutical interventions.

36. In the main, however, decisions relating to healthcare systems within the scope of Module 3 of the Inquiry, were not made by Cabinet and were my responsibility as Minister for Health and Social Services during my tenure. There was inevitably some overlap where Cabinet discussions and decisions touched upon healthcare system issues. For example, minutes of the 14 July 2021 Cabinet meeting note, in the context of a discussion regarding the relaxation of self-isolation requirements for people who had received two vaccine doses, that Cabinet agreed that it was important to ensure there were additional protections for health and social care. The minutes are exhibited in **M3MEM01/002 – INQ000129973**. Where I have raised or discussed relevant decisions with Cabinet in this way, I have referenced them throughout the remainder of my statement below.

Groups engaged with the response of the healthcare system to the Covid-19 pandemic

37. I attended a weekly Covid-19 update meeting from May 2021 when I was appointed as Minister for Health and Social Services until meetings were paused on 25 April 2022. Meetings were held on a weekly basis and attended by the First Minister, the Chief Medical Officer for Wales and the Director General/Chief Executive of the NHS. The purpose of the group was to discuss the latest Technical Advisory Cell reports, including Covid-19 rates, modelling, new variants and vaccination as well as the Test, Trace, Protect Programme.

38. In terms of cross-UK groups, I attended:

    a. the UK Operations Group (Covid O) in my capacity as Minister for Health and Social Services from June 2021 to March 2022. These meetings were established to discuss various issues relating to the pandemic and were chaired by the UK Cabinet Secretary.

    b. Meetings with the other health ministers in the UK during which we would share concerns on Covid-19 rates, hospital pressures, vaccinations and non-pharmaceutical interventions.

    c. Meetings relating to border control which were also attended by representatives from other UK Government departments such as the Foreign and Commonwealth Office or covering policy areas such as transport, the economy and tourism.

39. I have been asked to provide details of my working relationship with health ministers in England and the other devolved governments, together with the extent of any cross-UK liaison in relation to the response of the healthcare system to the pandemic.

40. As set out earlier in this statement, when I was appointed as Minister for Health and Social Services, I began attending regular meetings with the health ministers in the UK Government and the other devolved nations and I was pleasantly surprised by the amount of contact I had with my counterparts. During the height of the pandemic, the health ministers from each of the four nations met almost weekly. This was entirely down to the determination and commitment of Matt Hancock and Sajid Javid who, as health ministers, took the relationships with the devolved nations very seriously albeit that I felt that the Welsh Government's influence over any decisions reached by the UK Government was limited. These meetings continued until in or around the summer of 2022.

41. The purpose of these meetings was to discuss and share information relating to Covid-19 rates, hospital pressures, vaccinations and non-pharmaceutical

interventions. I found these meetings to be a very useful sounding board and considered that there was a degree of trust amongst the health ministers (which was unusual considering that we were all from different political parties). There were very few people who understood the pressure we were under when making decisions and it was helpful to be able to meet to share experiences and anxieties. The virus was moving in waves around all four nations and the meetings served as a useful forum within which to compare notes on what was happening in the other nations in real time and to learn from one another.

42. Whilst there was not any obligation to make the same decisions in relation to the respective healthcare systems, there were circumstances in which it made sense for us all to agree to coordinate policies and timings in relation to communicating with the public. This was especially true when it came to making decisions about the advice from the Joint Committee on Vaccination and Immunisation on the eligibility for vaccines, which I am aware will be dealt with in further detail in Module 4.

43. Accordingly, there was cross-UK liaison in the sense that all health ministers across the four nations were open to sharing and discussing information relating to the pandemic; at times this would culminate in a coordinated position in relation to the response of the respective healthcare systems but not always.

44. Notwithstanding, healthcare is a devolved function which means that, fundamentally, it is for the Welsh Government to make its own decisions on matters relating to the healthcare system in Wales. This is important because it enables the Welsh Government to tailor its decision making in accordance with the needs of the people of Wales, which may differ from those in the other nations.

45. An example of where I took a different approach in relation to the response of the healthcare system was in relation to shielding. In September 2021, the UK Government made a decision to close its shielding programme and return to the situation pre-Covid-19 where people managed their own conditions with their health professionals. In a Ministerial Advice dated 9 September 2021 which I exhibit at **M3MEM01/003 – INQ000353269** I was presented with the option of closing the shielding programme in Wales in accordance with the UK Government

but I did not feel that it was necessary to put an end to our shielding programme at that time because I felt it was important to maintain a cautious approach in view of the rising numbers of cases of Covid-19.

46. Another example of where I took a different approach is in relation to long Covid. I was aware that the UK Government had established multi-disciplinary long Covid clinics. However, in accordance with the advice I received from policy officials, I agreed that the more appropriate service model for Wales was through existing primary and community care structures so that care and support could be tailored in accordance with patient needs as close to their home as possible. I exhibit the relevant Ministerial Advice dated 10 June 2021 at **M3MEM01/004 – INQ000145131.**

47. At no point did we ever deliberately take a different approach from other nations as we always tried to do what was best for Welsh patients and healthcare workers. Also, we were very clear that remote consultations with GPs were here to stay whereas in England they were keen to get back to face-to-face consultations as soon as possible. I have detailed in the concluding remarks of my statement further below why I consider this approach to particularly benefit the people of Wales.

48. Notwithstanding all of that, there were times during the relevant period in which I felt that a joined up four nations approach was required. I have already mentioned earlier in this statement that one example of that was in relation to the eligibility of vaccines. In that instance, the four nations were able to agree a coordinated approach but there were other instances in which that was not achievable. When the Omicron variant emerged, the First Minister, together with the First Minister of Scotland, wrote to the Prime Minister to seek an urgent COBR meeting to discuss four nation planning for a worst-case scenario for Omicron. However, the Prime Minister's spokesman declined. I found this very disappointing as I felt a coordinated approach would be the most effective response to the Omicron variant.

Limitations on Decision-Making

49. I am asked to comment upon the extent to which the response of the Welsh healthcare system to Covid-19 insofar as decisions taken by me or delegated by me to others was constrained by or contingent upon other Welsh Ministers or their officials. I consider it important to emphasise as an overarching point in the first instance that decisions in government are always constrained by financial considerations.

50. Whilst the First Minister took a lead role when it came to the discussions surrounding vaccinations and Test, Trace, Protect, I never felt constrained by this. We were acting as a team. By the time I was appointed as Minister for Health and Social Services, the then-First Minister, Mark Drakeford, had considerably more experience than I in relation to the pandemic. Accordingly, and in his role as First Minister, he would often take a leadership role in the various meetings. However, when it came to decision-making as to the response of the healthcare system, I would take those decisions without any limitations placed upon me by other Welsh Ministers or their officials.

51. There would also be occasions where both the then-First Minister and I were involved in the decision-making process. A key example of this is set out further below in respect of the Military Aid to the Civil Authorities ("MACA") requests made in late-2021. Once more, I never felt constrained when these joint decision-making processes arose.

52. Following my appointment, I was the main decision-maker when it came to all other aspects of the NHS during the pandemic. I relied on my experienced and hard-working officials to provide me with advice which I used in decision-making. Again, this was a collaborative approach and at no time did I consider my decisions to be constrained by their efforts and input.

53. As to the extent to which that response was constrained by or contingent upon other UK or devolved government ministers or departments, as I've already stated above, healthcare is a devolved function which means that it is for the Welsh Government to make its own decisions.

54. At the start of my tenure as Minister for Health and Social Services, I had regular meetings with my counterparts across the rest of the United Kingdom. During these meetings, we generally agreed to act together when it came to announcing our position on matters including vaccination and following the advice of the Joint Committee on Vaccination and Immunisation ("JCVI").

55. It is correct to note that finance was a constraint towards the end of the relevant period generally. As a devolved area, the Welsh allocation of funds to healthcare is largely set by how much the UK Government spends on healthcare in England in accordance with the Barnett consequential funding formula. However, it is also correct that the most impactful financial constraints are those that have been felt post-pandemic during the recovery period, which I understand is outside of the relevant period being considered by the Inquiry.

Engagement with Specified Persons / Organisations

56. The Inquiry has asked me to provide an outline of the ways in which I worked with the following persons/organisations on matters relating to the response of the NHS in Wales. At paragraph 67 onwards of his statement, Vaughan Gething sets out the relationships established in his role as Minister for Health and Social Services at the outset of the relevant period and enduring throughout his tenure. Upon my appointment, I stepped into these established patterns and have summarised how these proceeded during my tenure as Minister for Health and Social Services during the remainder of the relevant period below:

    a. **The Chief Medical Officer for Wales** – The Chief Medical Officer post in Wales is a director level post which reports to the Director General of the Health and Social Services Group who in turn reports to the Permanent Secretary. Throughout my tenure as Minister for Health and Social Services during the relevant period I worked very closely with the Chief Medical Officer for Wales and met him on a weekly basis at the wider meeting to update on Covid-19. The Chief Medical Officer would provide me with independent professional advice and guidance on matters relating to health strategy, public health, quality and safety, research and

development, and the latest trends in relation to Covid-19 both within Wales and internationally.

b. **The Chief Executive Officer of NHS Wales –** I have set out the nature of this role further above. During the relevant period, I worked very closely with the Chief Executive Officer for NHS Wales and had at least twice weekly meetings with them during the relevant period. We had a regular weekly meeting at which an update on Covid-19 was given, as well as a detailed picture of the impact on the broader NHS. This was in addition to the regular weekly meetings to update on Covid-19.

c. **The Chief Nursing Officer for Wales –** 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. During the relevant period, and whilst we did not have individual one-to-one meetings, I had regular meetings with the Chief Nursing Officer for Wales in that we both attended quarterly meetings with the Royal College of Nursing and with the Royal College of Midwives. At these meetings, the Chief Nursing Officer for Wales (or a Nursing Officer) supported me in a professional capacity with discussions at these meetings focusing on professional and nursing matters and professional midwifery matters relating to Wales. In addition, the Chief Nursing Officer for Wales has contributed to formal Ministerial Advice on Covid-19-related work and issues submitted to me. I have detailed (and exhibited) one such example of this later in my statement in respect of maternity and neonatal visiting guidance.

d. **The Chief Executive Officers of the Local Health Boards –** The formal relationship between the Health Minister and the Local Health Boards is via the Chairs of the Local Health Boards rather than their Chief Executive Officers. I met with the Chairs on a quarterly basis, but Chief Executive Officers were invited to two of these meetings per year. The impact of Covid-19 on NHS services was regularly discussed at these meetings.

e. **The Welsh NHS Trusts and Special Health Authorities –** I held quarterly meetings with the NHS Trusts and Special Health Authorities and towards the end of the pandemic I also held monthly meetings with the Welsh Ambulance Services Trust as there was extreme pressure on the flow through Emergency Departments. During the relevant period, these meetings ran from July 2021 to May 2022. I have outlined my involvement with the Welsh Ambulance Services Trust in detail later in this statement.

f. **English and UK-wide health bodies such as Public Health England –** I did not have regular meetings with English and UK-wide health bodies such as Public Health England although, as detailed elsewhere, I had regular communication and meetings with my counterparts in UK Government and the other devolved governments.

g. I had regular meetings with the **British Medical Association, the Royal College of Nursing, the medical Royal Colleges and trade union representatives.**

57. I am asked by the Inquiry to provide a summary of my daily working pattern as Minister for Health and Social Services during the relevant period. Given the variation in my working pattern on a day-to-day basis, there is no one single summary that would accurately reflect a 'typical' working day. A typical working week might involve the following:

a. On Mondays, I would hold meetings with my private office and the Director General of the NHS in Wales. I would also attend Cabinet, which always occurred on a Monday (and, during the relevant period, often far more

frequently). At the start of the pandemic, I would also regularly attend meetings with my counterparts in the other UK nations.

b. On Tuesdays, I would often have a 'catch up' meeting with key people in the Welsh Government including the First Minister. I would also have a Labour Group meeting, a meeting with my Deputy Ministers and would attend plenary.

c. On Wednesdays, I was often required to attend committee meetings of the Senedd and would frequently take questions in the Chamber. I would also meet with numerous key stakeholders in the health field. At the start of the pandemic, I had regular meetings on issues pertaining to JCVI advice and vaccinations, which were often attended by UK Government ministers.

d. On Thursdays, I would generally meet with the many health stakeholders, including representatives from trade unions and the Royal Colleges. At the start of my tenure as Minister for Health and Social Services, I regularly attended Covid-O meetings.

e. On Fridays, I would attempt to keep my diary free in order that I could continue to undertake my duties as a Regional Member of the Senedd.

f. Whilst I would try to ensure Saturdays were available for me to meet personal commitments, I would spend Sundays clearing ministerial decisions and reading briefing.

58. Alongside the above, there were other certain 'regular' appointments in my working days during the relevant period, including the daily ministerial calls.

59. Aside from the above, other appointments and / or engagements I would undertake on a more 'ad hoc' basis during the relevant period included:

a. Media appearances;

b. Regular meetings with local government representatives (for example, regarding Delayed Transfers of Care, which I have detailed further below);

c. Meetings with representatives for specific non-Covid-19 conditions, such as cancer, neurological conditions and end-of-life representatives;

d. Visits to hospitals once they could be undertaken safely and in accordance with the relevant restrictions in place at the time;

e. Occasional surgeries for Members of Senedd in which they could raise any concerns they had with me for discussion.

Ensuring Consistency

60. I have been asked to describe the extent to which the Welsh Government had responsibility for ensuring consistency across the NHS in Wales in its response to the Covid-19 pandemic; any formal structures or mechanisms intended to promote consistency across the NHS in Wales, such as mandatory guidance; and any areas where Local Health Boards had discretion to formulate their own policies or guidance, in particular identifying areas where there was no national guidance or advice.

61. These matters are addressed fully in Vaughan Gething's Module 3 statement to the Inquiry at paragraphs 33 to 40. These structures were already in place at the time of my appointment and remained throughout.

62. Local Health Boards have operational decision-making with a focus on day-to-day activities and resource allocation and dealing with immediate concerns, such as managing patient flow, staffing, and logistics within hospital settings. In such areas they have broad discretion to formulate their own local policies and/or guidance. National guidance or advice issued by the Welsh Government focused on the strategic direction of the healthcare service in Wales or provided frameworks in which Local Health Boards could operate some discretion to ensure they provided for the needs of their local population. As set out in Vaughan Gething's statement, the NHS in Wales operates on a strong planning foundation and plans were submitted and approved by the Welsh Government. During the pandemic period the Welsh Government issued guidance to the Health Boards on the management of the pandemic and I understand a list of all guidance relevant to Module 3 has been provided to the Inquiry by Dr. Andrew Goodall and I exhibit it here at **M3MEM01/005 - INQ000227428**.

Impact of Decisions

63. I have been asked to describe how I considered the impact of my decisions as Minister for Health and Social Services upon disabled people, people who were

clinically vulnerable, clinically extremely vulnerable and severely immunocompromised, those from minority ethnic backgrounds or lower socio-economic backgrounds and/or groups with existing health inequalities.

64. Vaughan Gething's Module 3 statement to the Inquiry describes Wales' statutory duties and commitment to equality (at paragraphs 146 to 151), the role of equality impact assessments in Welsh Government decision-making (at paragraphs 152 to 155), the creation and function of the Black, Asian and Minority Ethnic Covid-19 Advisory Group and the Covid-19 Moral and Ethical Advisory Group for Wales (at paragraphs 231 to 241), and the Welsh Government's approach to the clinically vulnerable and clinically extremely vulnerable and other groups with health inequalities (at paragraphs 132 to 142). I do not intend to repeat these matters, which are of equal relevance to my tenure as Minister for Health and Social Services in the relevant period.

65. Throughout the relevant period, I considered the results of impact assessments and equality impact assessments before making decisions. As indicated in Vaughan Gething's statement, it was not always possible for these to be formally published impact assessments produced alongside decisions as they were made. In those circumstances, such assessments formed part of the Cabinet papers, Ministerial Advice and / or briefings with which I was provided prior to making a decision. I exhibit a list of published Impact Assessments as **M3MEM01/005a - INQ000227405**. This exhibit covers those published throughout the relevant period and spanning both of our tenures as Minister for Health and Social Services.

66. As demonstrated by the creation and function of the Black, Asian and Minority Ethnic Covid-19 Advisory Group and the Covid-19 Moral and Ethical Advisory Group for Wales (detailed in Vaughan Gething's statement and referred to above), the Welsh Government sought to ensure that decisions were informed and in the best interests of the most vulnerable in Wales. Thus, whenever I made a decision, I would have particular regard to whether it would positively impact those identified as being most disproportionately affected by the pandemic.

67. Non-exhaustive examples of decision-making for which I was responsible, in which I found the impact assessments included in advice to me particularly pertinent include:

a. A Ministerial Advice provided to me on 10 June 2021, exhibited previously in **M3MEM01/004 - INQ000145131**, in which I was asked to approve funding for the Adferiad (Recovery) programme, to permit the development of community services to support those who were recovering from the effects of Covid-19, either directly as a result of infection (long Covid) or indirectly as part of the broader effects of the pandemic. The Advice notes that the package recommended would reduce health inequalities to achieve a fairer Wales, providing response and recovery for those unequally impacted by Covid-19 e.g. Black and Minority Ethnic people, those with long-term conditions, people experiencing social and economic deprivation and older people including those in long term care.

b. A Ministerial Advice dated 14 April 2022, exhibited in **M3MEM01/006 - INQ000177072**, seeking my approval of the "Programme for transforming and modernising planned care and reducing waiting lists in Wales". The Advice includes the conclusions of the Impact Assessment:

> *People from ethnic minority communities, older people, children, and young people and those with mental health issues have all felt an impact not only from COVID-19 but also from the restrictions that were imposed to keep us safe...*
>
> *The plan should have a positive impact on people across Wales as it sets out the strategic direction for rebuilding key health and social care services to address the significant impact of long waits and people not contacting the health services early enough to maximise their possible outcomes. It recognises that if we do not change and rebuild this would compound the current negative impact of covid and the lengths of waits could further increase, and patient outcomes would be significantly impacted...*
>
> *Health and social care services need to plan to meet the needs of their respective populations and must do so regardless of age, race,*

religion, sex, and sexual identity, etc. Organisations need to ensure that people have equal access to diagnosis and treatment.

Some groups of people have been adversely affected by COVID-19 and the plan reinforces the need for organisations to mitigate this.

68. Further, and as demonstrated in the aforementioned list of published impact assessments, such assessments were regularly provided to Cabinet ahead of making 21-day review decisions. Whilst provided in the context of those review decisions, once considered by me, they remained relevant. I kept them in mind and under general consideration, not only in Cabinet, but also when making any Ministerial portfolio decisions. This occurred before and after my appointment as Minister for Health and Social Services. For example, prior to my appointment, I was responsible for determining when and how tourism facilities, pubs and hospitality facilities would re-open. Alongside considering the health implications of the potential for the further spread of the virus, we were given a detailed breakdown of the profile of the kind of people who worked in this sector. These were on the whole younger and had a larger proportion of ethnic minorities working in what was already a precarious sector with many on zero-hour contracts. We needed to be concerned not just about the spread of Covid-19 but also about the economic and mental health implications for this cohort of people.

69. A summary report on the First Minister's Black, Asian, Minority Ethnic Covid-19 Advisory group was published in September 2021, exhibited in **M3MEM01/007 - INQ000066078.** This referred to the report published by the Socio-Economic Subgroup on 25 June 2020, which highlighted the disproportionate impact of the pandemic on members of Black, Asian and Minority Ethnic groups and had made 37 recommendations. The summary report in September 2021 considered the response by the First Minister to that report on 24 September 2020 and the work that had been undertaken in respect of those recommendations, which were all accepted by the Welsh Government. These reports and the recommendations relevant to the healthcare sector are described in Andrew Goodall's Module 3 WGO1 statement (at paragraphs 252-254). The September 2021 report described the creation and work of the Black, Asian and Minority Ethnic Covid-19 Advisory

Group and the Covid-19 Moral and Ethical Advisory Group for Wales and confirmed that the 37 recommendations had been accepted and were being implemented.

70. I was not individually responsible for the implementation of any of the recommendations as these were primarily taken forward by officials. However, the Anti-Racist Wales Action Plan (described below), which sought to take forward several of the recommendations, was considered and agreed by Cabinet prior to its publication and so I had collective involvement in that capacity.

71. The Anti-Racist Wales Action Plan was published on 20 July 2022. Whilst outside of the relevant period with which the Inquiry is concerned, the Welsh Government's work to address such matters has continued beyond the pandemic. Goal 5 of this Plan is focused upon tackling health inequalities which, as I set out in the concluding remarks of this statement, is fundamental to any future pandemic response. The Annual Report for 2022-2023 sets out what progress has been made in respect of the Plan. This has included action to progress the general goal of making the NHS in Wales anti-racist and improving upon the collection of data in relation to race, ethnicity and intersectional disadvantage, alongside more specific actions targeted against identifying and breaking down barriers that prevent equitable access to healthcare services for Black, Asian and Minority Ethnic people in areas such as maternity and neonatal safety and mental health. I exhibit the original Plan and the Annual Report at **M3MEM01/008 - INQ000227788** and **M3MEM01/009 – INQ000480730** respectively. Vaughan Gething's Module 3 statement describes the Welsh Government's actions in response to the healthcare recommendations arising out of the June 2020 report and the relevant parts of the Anti-Racist Wales Action Plan in further detail from paragraph 164 of that statement.

Available Data and Modelling

72. There were several categories of data and modelling available during the relevant period regarding the NHS healthcare system in Wales and its capacity to respond to a pandemic. Many of these were established prior to my appointment as Health

Minister and have been outlined in Dr. Andrew Goodall's statement (M3-WGO-01) and Judith Paget's statement (M3-WGO-02) in detail.

73. One of the main sources of data available to myself and other Ministers during the pandemic was the Knowledge and Analytical Service's Data Monitor. This was prepared by the Welsh Government's Knowledge and Analytical Service from March 2020, with input from NHS Wales (and others). It drew on a wide range of sources, including those detailed further below, and provided a compendium of pandemic-related statistical information in one document to enable trends around the virus and its associated harms in Wales to be captured.

74. Whilst the topics and sources varied over the course of the relevant period, the Data Monitor generally covered the following themes:

    a. Cases, deaths and vaccinations;
    b. Health and social care;
    c. Shielded and vulnerable people;
    d. Attitudes and behaviours;
    e. Economy and labour market; and
    f. Public services.

75. The Data Monitor later developed into the Covid-19 in Wales interactive dashboard, which was published on the Welsh Government's website for the first time on 19 April 2021. This began to replace the internal Data Monitor save for where there was data that could not be incorporated into the dashboard. Whilst there were some changes to content to reflect that this was now a public-facing document, the overarching themes used broadly mirrored those in the internal monitor and much of the key content remained.

76. There are several other sources which I am aware that my officials would access and, where relevant, these (or data derived therefrom) would routinely feature in briefings and Cabinet papers to assist with decision-making process, including:

a. The **Secure Anonymised Information Linkage ("SAIL") databank** is a trusted secure research environment for data linking in Wales. This was used by Swansea University to produce data analysis using anonymised health data that was specific to Wales. The databank was run and owned by Swansea University, but received funding from Health and Care Research Wales and UK Research and Innovation's Economic and Social Research Council. They examined the impact of Covid-19 on society in Wales and on the NHS, as well as the effectiveness of treatment options and other non-pharmaceutical interventions. By the time I became Minister for Health and Social Services in May 2021, we were largely reliant on modelling produced by Swansea University from the Secure Anonymised Information Linkage databank and I have set out further below the results of a Policy Modelling Update undertaken around that time.
b. The **Covid Intelligence Cell** ("CIC") was established on 21 September 2020. It published surveillance in order to provide a single authoritative source of situational awareness of transmission and provided a comprehensive overview of the incidence of Covid-19 across Wales.
c. **Public Health Wales** led the collection, analysis and dissemination of rapid surveillance data for Covid-19, covering topics such as test positivity, case rates, deaths and vaccination uptake.
d. **Digital Health and Care Wales** took the lead role in collecting daily returns from Local Health Boards and NHS Trusts.
e. **The Director General of the Health and Social Services Group/Chief Executive of the NHS** (Andew Goodall and later Judith Paget) produced management information collected from the chief executives within the NHS in Wales which included:
    i. The total number of Covid-19 related patients in hospital beds;
    ii. The number of confirmed Covid-19 patients in hospital occupying a bed;
    iii. The number of occupied surge and normal beds in a critical care environment;
    iv. The number of Covid-19 related patients in critical care;
    v. Sickness absence of NHS and social care staff;
    vi. The percentage of adult care homes closed to admission.

77. the Technical Advisory Group provided regular Policy Modelling Updates, the first of which is exhibited at **M3MEM01/010 – INQ000066349** and predates my appointment as Minister for Health and Social Services. This explored the result of the policy modelling carried out by Swansea University to understand possible futures around the pandemic. These updates continued throughout the relevant period and I am aware that Andrew Goodall has provided detail upon the modelling available in his statement (M3/WGO/01) and so I do not repeat it here. These updates were made available to me in my capacity as Minister for Health and Social Services and as a member of Cabinet generally.

78. The Chief Executive Officer of the NHS, (Andrew Goodall from the outset of my tenure and then subsequently Judith Paget), was my principal point of contact and information for the NHS in Wales. As I have referred to earlier in this statement, I had regular weekly meetings with the Chief Executive Officer of the NHS, Judith Paget, which included an update on the impact of Covid-19 on the NHS. I would also meet regularly with Chairs and Chief Executives of NHS bodies to ensure that I was kept informed of what was happening "on the ground" in terms of the impact of the pandemic on the healthcare system, and what they needed by way of support.

79. As I have set out in further detail below, I received regular 'NHS Covid updates' and 'latest figures' updates by e-mail, which included data on hospital admissions, critical care capacity and bed occupancy.

80. It was important for me to keep informed of the views of frontline workers and healthcare staff throughout the pandemic, which I sought to do via the regular meetings with the British Medical Association, the Royal College of Nursing, the medical Royal Colleges and trade union representatives I have referred to earlier in my statement. The meetings I had with Chief Executives of NHS bodies provided another opportunity to receive the views and feedback of staff in the respective bodies. On a formal basis, I recall that these were twice annually. However, I did have some one-to-one informal meetings with them in addition, particularly if I visited an individual Health Board or Trust.

Part C: Non-Covid-19 Treatments

81. Throughout the relevant period, I was aware that the Covid-19 pandemic had had an unprecedented impact on routine NHS care. In a Ministerial Advice dated 20 July 2021, which I exhibit at **M3MEM01/011 – INQ000103981**, I was advised that between March 2020 and May 2021:

    a. Total waiting lists had increased by 33% and stood at 608,062.
    b. 26-week performance had deteriorated from 81.9% to 52.8%.
    c. Numbers waiting over 26 weeks had increased by 247% and stood at 286,996.
    d. Numbers waiting over 36 weeks had increased by 705% and stood at 227,753.
    e. Numbers waiting over 52 weeks increased by 2,140% and stood at 169,293.

82. Accordingly, there was a clear need to help NHS routine care recover from the impact of the pandemic to ensure a safe return to routine arrangements for non-Covid-19 conditions and reduce waiting times for elective surgery and delays in treatment. Further to the Ministerial Advice exhibited above at **M3MEM01/011 – INQ000103981**, I agreed to invest £140m in the NHS in Wales comprising £100m to enable NHS organisations to access additional capacity to make progress in accessing and treating those patients that had been waiting for a significant period of time, and £40m to enable NHS organisations to undertake changes to their existing estate in order to enable routine care activity to increase whilst still ensuring appropriate delineation with areas used for treating patients with Covid-19 with other emergency care conditions. This was in addition to the £100m that my predecessor Vaughan Gething had agreed to invest following Ministerial Advice dated 19 March 2021 and exhibited at **M3MEM01/012 – INQ000116613**, which I subsequently allocated as set out in a press release dated 20 May 2021 at

M3MEM01/013 - INQ000283275[1]**.** Details of the allocation are set out later in this statement.

83. In a Ministerial Advice dated 17 September 2021 and exhibited at **M3MEM01/014 – INQ000145144,** I allocated a further £148m of funding to support the NHS to increase capacity and reduce waiting lists.

84. Notwithstanding the additional funding provided to the NHS, and the attempts made by Local Health Boards to keep pace with demand, there remained considerable delays in the healthcare system.

85. As at the end of February 2022, the total waiting list was 691,885 (an increase of 235,076 since March 2020) and the number of people waiting more than 36 weeks was 251,647 (an increase of 223,353 since March 2020).

86. Accordingly, it was clear that a new approach was required in order to address the backlog. On 26 April 2022 I published "*Our programme for transforming and modernising planned care and reducing waiting lists in Wales*" which I exhibit at **M3MEM01/015 - INQ000270477** and this was backed by additional funding. I have previously exhibited the ministerial statement dated 14 April 2022 at **M3MEM01/006** – **INQ000177072**, and I exhibit the oral statement announcing the plan at **M3MEM01/016 – INQ000480070.** This set out the Welsh Government's intention to recover, reset and transform planned care services by increasing the capacity of the health service; prioritising diagnosis and treatment; transforming the way elective care is provided by setting up dedicated surgical facilities; and providing better information and support to people for those waiting for treatment. I also set the following targets to reduce waiting times:

    a. No one will wait longer than a year for their first outpatient appointment by the end of 2022;
    b. Increase the speed of diagnostic tests and reporting to eight weeks and to 14 weeks for therapy interventions by Spring 2024;

[1] 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 [INQ000480064]

c. No one will wait more than a year for an operation in most specialties by Spring 2025;
d. 80% of people who receive a cancer diagnosis should start first definitive treatment within 62 days from the first point when cancer was suspected by 2026.

87. The "*programme for transforming and modernising planned care and reducing waiting lists in Wales*" was also instrumental in addressing the recommendations in the report "*Waiting Well – the impact of the waiting times backlog on the people in Wales*" that was sent to me by the Health and Social Care Committee of the Senedd. I exhibit a letter that I sent to the Chair of the Health and Social Care Committee in May 2022 addressing the recommendations by reference to the "*programme for transforming and modernising planned care and reducing waiting lists in Wales*" at **M3MEM01/017 - INQ000066520.**

88. Progress against the plan is off-target and has been affected by a range of factors. These include:

a. Successive waves of coronavirus infections;
b. Increasing rates of referrals for treatment as demand returns to pre-pandemic levels (for example, there was an average of 4,342 daily referrals for first outpatient appointments in February 2024, which is a 2.4% increase compared to February 2023);
c. The impact of industrial action by Agenda for Change trade unions and members of the British Medical Association;
d. The very challenging financial climate in which the system has been operating over the last two years.

89. In February 2024, I am advised that there were just over 763,100 patient pathways waiting to start treatment, which is 68.1% higher than in May 2020. Notwithstanding, waiting times of more than two years have fallen for 23 consecutive months.

90. In addition to the above, I am aware that the Inquiry is particularly interested in a number of specific steps undertaken by the Welsh Government during the relevant period and I shall now proceed to address each of those below.

The Local Choices Framework

91. Insofar as other steps taken to return the NHS to its routine arrangements, I am aware that the Health and Social Services Group sought to agree a framework of actions to mitigate the potential risk of harm to patients who required essential services. This was referred to as the Local Options Framework and was originally issued on 10 December 2020. This was prior to my appointment as Minister for Health and Social Services, although I am aware that Andrew Goodall has previously referenced this in his statement to the Inquiry M2B/HSSG/01 in Module 2B. However, as I had no involvement with such matters, I do not intend to address the same further.

92. After my appointment in May 2021, I am aware that a revised Local Options Framework was issued on 1 October 2021. This was issued in response to the increasing infection rates in Wales during that period and to strengthen the existing mitigations in place. Again, this was a matter undertaken by the Health and Social Services Group in which I had no involvement. Once more, I understand further detail is set out on the revised Framework in Andrew Goodall's Module 2B statement M2B/HSSG/01 but, given my lack of involvement, I am unable to assist the Inquiry further on this issue.

Discharge to Recovery and Assess

93. Similarly, and insofar as the implementation of the Discharge to Recovery and Assess (D2RA) pathway, this was already established prior to the pandemic and commencement of the relevant period, and thus significantly prior to my appointment as Minister for Health and Social Services. I am aware that the foundation for this pathway was built upon evidence that hospitals are not always the best place for frail people to receive services. I am also aware that the D2RA model underpinned the Covid-19 hospital discharge guidelines, the details of which are set out in Andrew Goodall's statement M3/WGO/01 at paragraph 470 onwards.

However, I was not involved in the original implementation of the D2RA pathway or the subsequent initial Covid-19 discharge guidance.

94. Once I became Minister for Health and Social Services, I was asked via the Ministerial Advice process to approve and agree to the publication of revised guidance on discharge that had been drafted by officials. The D2RA pathway generally underpinned the Welsh Government's approach to healthcare throughout. For example, on 4 February 2022, I (together with the Deputy Minister for Social Services, Julie Morgan, and the Deputy Minister for Mental Health and Wellbeing, Lynne Neagle) jointly published '*Right Care, Right Place, First Time*', which was a Policy Handbook to cover the years 2021 to 2026 and set out six goals for urgent and emergency care. I exhibit a copy of this Handbook at **M3MEM01/018 – INQ000480078**.

95. As may be seen therein, Goals 5 and 6 particularly sought to focus on good discharge practice through the continued use of the D2RA pathway as an active recovery model, with the 'Home First' ethos at its heart. The intention was for this approach to focus on what mattered to the individual, maximising recovery and independence whilst minimising exposure to in-patient infection and risk and avoiding deconditioning. The intention was for this to be achieved whilst providing a seamless transfer to longer-term support in the community if required. Successful implementation of this was intended to improve outcomes for service users and support an effective 'whole system flow' to enable optimal hospital care for those who needed it.

Health and Social Care in Wales - Covid-19: Looking Forward (March 2021)

96. In March 2021, '*Health and Social Care in Wales – Covid-19 Looking Forward*' was published. Whilst this was before my appointment as Minister for Health and Social Services, I jointly approved its publication in my role as Minister for Mental Health, Wellbeing and Welsh Language. On 16 March 2021, I received Ministerial Advice MA/VG/0955/20 seeking approval for such publication jointly with Vaughan Gething, as Minister for Health and Social Services, and Julie Morgan, as Deputy Minister for Health and Social Services, a copy of which is exhibited at **M3MEM01/019 – INQ000136849**.

97. The publication of '*Health and Social Care in Wales – Covid-19 Looking Forward*' sought to set high level direction for overall recovery and a renewal pathway for the health and social system by:

    a. Setting expectations in relation to recovery across the health and social system;
    b. Identifying opportunities to build an improved integrated health and social care system;
    c. Managing the existing and long-term impacts of Covid-19, alongside improvements;
    d. Setting priorities and highlighting the need to focus on the wellbeing of the health and social care workforce.

98. It was intended that this document would be public-facing and would be underpinned by the refresh of '*A Healthier Wales*' (which was first published in June 2018) and would complement the NHS Wales Annual Planning Framework 2021-22 which had already been issued on 14 December 2020. It was intended to set out the Welsh Government's ambitious but realistic approach to building back the health and care system in Wales on a 'whole system' approach, which included primary and community care, effective hospital services, seamless social care, supportive mental health services and a supportive, resilient and motivated workforce. It focused on the impact of Covid-19 on each of these individual NHS sectors and the priorities for their development, together with the lessons learned, the opportunities to retain best practice (such as the ongoing use of technology) and the challenges. In relation to planned care and waiting times, it said: "There is a fundamental need to change the way services are delivered. New ways of working, and new pathways which sees the adoption of best practice consistently across the country in line with '*A Healthier Wales*'.

99. On 19 March 2021, I agreed the recommendations set out in MA/VG/0955/20, a copy of this agreement is exhibited at **M3MEM01/020 – INQ000479973**.

100. '*Health and Social Care in Wales – Covid-19 Looking Forward*' was published on 22 March 2021, a copy of which is exhibited at **M3MEM01/021 – INQ000066129**. This publication was accompanied by a joint Written Statement from Vaughan Gething, Julie Morgan and I, which is exhibited at **M3MEM01/022 – INQ000275732**.

101. On 9 July 2021, I was copied into Ministerial Advice MA/JMSS/2420/21 which sought agreement from the Deputy Minister for Social Services, Julie Morgan, to the draft Social Care Recovery Framework. A copy of this advice is exhibited at **M3MEM01/023 – INQ000145135**. This Framework sought to build upon previous recovery planning and the publication of '*Health and Social Care in Wales – Covid-19 Looking Forward*'. It followed extensive work undertaken with sector representatives, via the Social Care Sub-group of the Health and Social Services Planning and Response Group and set out the major structural considerations, issues and themes needed to plan effectively for recovery. It also provided priorities and commitments largely on a 'whole-sector' basis and was supported by accompanying Welsh Government-specific priorities and commitments. Whilst I was aware of this Framework, its approval and publication was the decision of the Deputy Minister for Social Services.

<u>Together for a Safer Future: Wales' Long-Term Covid-19 Transition from Pandemic to Endemic (March 2022)</u>

102. In March 2022, '*Together for a safer future: Wales' long-term Covid-19 transition from pandemic to endemic'* was published. This was initially discussed in Cabinet on 24 January 2022 when, during consideration of a forthcoming review of the Health Protection (Coronavirus Restrictions) (No.5) (Wales) Regulations 2020, it was agreed by Ministers that officials, in consultation with trusted partners, should prepare a new transition plan to set out the direction of travel and key milestones in managing Coronavirus on an ongoing basis. I exhibit the Cabinet minutes for 24 January 2022 at **M3MEM01/024 – INQ000130027**.

103. The intention behind such agreement was to provide a public-facing transition plan that would communicate the change from an emergency footing to

managing Covid-19 alongside other respiratory infections and provide contingency plans to continue to keep Wales safe.

104. A draft was prepared by officials and, on 23 February 2022, I was provided with the first draft and asked to provide any comments on it. On 24 February 2022, I provided a revised draft exhibited at **M3MEM01/025 – INQ000480036** and further comments exhibited at **M3MEM01/026 – INQ000480035** to be considered by officials in finalising the document. Amongst other matters raised (including noting the publication of the Vaccination Plan that day), I was particularly keen to ensure that the full scope of the Welsh Government's research and waste water surveillance was referenced, along with ensuring that the best use of the limited funding available (due to the lack of any future additional support from the UK Government) was considered in the context of decisions being made about testing and self-isolation moving forward. I exhibit a copy of the e-mail chain setting out the above at **M3MEM01/027 – INQ000480034.**

105. In a Cabinet meeting on 28 February 2022, it was noted that work was underway to complete the Transition Plan with the intention being to present a final version to Ministers at a forthcoming Ministerial call. I exhibit the Cabinet minutes for 28 February 2022 at **M3MEM01/028 – INQ000130041**.

106. The final plan was discussed between Ministers during a Ministerial call held on 3 March 2022. The minutes of this call are exhibited at **M3MEM01/029 – INQ000361803**. The Plan outlined two planning scenarios: Covid Stable and Covid Urgent, with Wales entering a Covid Stable scenario at that time. A Covid Stable scenario meant that pressure on the NHS and care services was sustainable, but the necessary infrastructure would need to remain in place in readiness for any future fluctuations and / or new variants.

107. During discussion of the Plan, Ministers also considered a number of key proposed dates as follows:

a. Vaccination Plan, which had been published on 24 February 2022;

b. Transition Plan to be published on 4 March 2022, with no change to Regulations;
c. Devolved provisions of the Covid Act to expire on 24 March 2022;
d. Self-isolation, face coverings and risk assessments to become guidance (rather than Regulations), and workplace testing and systematic PCR testing for the general population to end (although PCR testing for health and social care staff and vulnerable settings plus free lateral flow tests to continue) on 28 March 2022;
e. Testing transition to end on 27 May 2022;
f. Lateral flow tests to no longer be available for free, and guidance for self-isolation, routine contact tracing and self-isolation payments to come to an end in late-June 2022.

108. Discussions between Ministers regarding the above included noting a need to monitor disruption in schools due to staff absence, noting the potential challenges in re-escalation of retained infrastructure without UK Government support and the recognition that continued testing at hospitals and of care home staff and health care workers would permit new variants to be monitored.

109. I was thereafter copied into MA/FM/0912/22, which sought the First Minister's approval for the publication of the Transition Plan. I exhibit a copy of that advice at **M3MEM01/030 – INQ000480049**. I understand that the First Minister approved this and, as indicated above, '*Together for a safer future: Wales' long-term Covid-19 transition from pandemic to endemic'* was published on 4 March 2022. I exhibit a copy of this document at **M3MEM01/031 – INQ000066072**.

<u>De-escalation of Covid-19 measures in NHS Wales to enable transformation and modernisation of planned and elective care and to reduce waiting times (20 May 2022)</u>

110. Finally, I have already detailed at paragraph 86 above my involvement in the publication of '*Programme for transforming and modernising planned care and reducing waiting lists in Wales*' on 26 April 2022. This was followed by a letter entitled '*De-escalation of COVID-19 measures in NHS Wales to enable*

transformation and modernisation of planned and elective care and to reduce waiting times', which was issued on 20 May 2022 and which sought to set out various steps which were to be taken immediately by all Welsh hospitals (if not already underway) in an attempt to de-escalate the Covid-19 measures that had become embedded in hospitals. A copy of this letter is exhibited at **M3MEM01/032 – INQ000353329** .

111. Whilst this letter sought to expand upon the earlier Programme, I was not involved in its approval, with the letter being jointly issued by the Deputy Chief Medical Officer, Professor Chris Jones, and the Chief Nursing Officer, Sue Tranka.

112. I understand that webinars were also provided to support hospitals with this transition although, again, I was not directly involved in the provision of these.

Part D: Increasing Capacity

113. The Inquiry has indicated that it is interested in understanding the impacts of the contingency measures formulated in various Welsh Government plans and frameworks issued during the relevant period. To be clear, these plans (which I have detailed below) would be based on modelling predictions of the reasonable worst-case scenarios for the NHS in Wales and any assessment of impact would be primarily based on the impact on Covid-19 transmission rates. Health Boards would report to Digital Health Care Wales what their workforce absences, bed capacity and medical equipment stocks were on a regular basis, which would be considered by the Health and Social Services Group, Welsh Government statisticians and the Technical Advisory Group. The effectiveness or impact of the contingency measures would then be considered at the regular reviews of the Covid-19 restrictions at Cabinet, a part of which was an assessment of how the NHS was doing and whether there was sufficient headroom capacity to ease restrictions further.

The Coronavirus Control Plan

114. The Welsh Government's 'Coronavirus Control Plan' was first published in April 2020 and is exhibited at **M3MEM01/033 - INQ000349794**. This publication pre-dated my appointment as Minister for Health and Social Services, and was

introduced by the then First Minister, Mark Drakeford, and my predecessor, Vaughan Gething as then-Minister for Health and Social Services. The Coronavirus Control Plan outlined the Welsh Government's systems in place to prevent the spread of coronavirus based on the principles of caution, proportionality and subsidiarity. These systems included: surveillance of the state of the virus in Wales from a local, regional and national perspective; implementing the test, trace and protect strategy; and the use of non-pharmaceutical interventions (e.g. imposing restrictions on the movement of people, the closure of business and venues, mandating the use of face coverings etc). The level and scale of intervention required would be dependent upon the rate of community transmission and the impacts on the healthcare system.

115. The Coronavirus Control Plan was further updated on 19 March 2021 and is exhibited at **M3MEM01/034 - INQ000066069**. Once more, this publication was introduced by the then-First Minister and Minister for Health and Social Services. This updated plan refreshed both the interventions at each local level and the range of indicators the Welsh Government would analyse alongside professional expert advice and intelligence from local partners.

116. The Coronavirus Control Plan was updated again in October 2021 and is exhibited at **M3MEM01/035 - INQ000082368**. This update followed my appointment and I and the First Minister introduced this report. This update was published at the time of the peak of the Delta wave in Wales; but whilst infections were at their highest level, the effectiveness of the vaccination programme meant that fewer people were suffering from severe illness and there were also fewer deaths. Notwithstanding that, we thought it was important to maintain key defences such as: a continued focus on vaccination; self-isolation on symptoms and following a positive test; Covid-19 risk assessments; wearing face coverings in indoor places; working from home where possible; a framework for education that allowed for escalation and de-escalation of protective measures; the use of the NHS Covid Pass; and personal behaviours such as hand washing and meeting people outside. A key driving factor behind retaining these defences was to avoid the NHS from becoming overwhelmed in the winter months, during which it would be facing greater pressures.

The Planning Framework 2021-2022

117. The Planning Framework 2021 – 22 was published on 14 December 2020 and is exhibited at **M3MEM01/036 - INQ000083224**. This was another publication which pre-dated my appointment. This framework required NHS organisations to set out over the course of 2021 – 2022 how they would manage to balance the needs of their populations, both for Covid-19 and non-Covid-19 activity and seek to minimise harm, building back stronger with a route map that leads to recovery and reconstruction. Plans were to be focused on the following five priorities, each of which addressed Covid-19 and non-Covid-19 service planning delivery: prevention; reducing health inequalities; primary and community care; timely access to services; and mental health.

Winter Protection Plan

118. The Welsh Government's Winter Protection Plan was published on 30 September 2020 and is exhibited at **M3MEM01/037 - INQ000300011** and was again introduced by my predecessor. The Winter Protection Plan set out for stakeholders the range of actions and contingencies that were expected to be put in place across the health and care system, and with wider partners, to manage the public health emergency and provide services over the coming challenging winter period. Such actions and contingencies included: continuing the test, trace, protect strategy and the vaccination programmes; ensuring that clinically extremely vulnerable persons continued to be considered in the response; promoting the use of the All Wales Covid-19 Workforce Risk Assessment Tool; and ensuring that sufficient stocks of PPE were available.

Impact of the above contingency measures in preparing the healthcare system to respond to the Delta variant and the Omicron variant

119. I have been asked to describe the impact of these contingency measures in preparing the healthcare system to respond to the Delta and Omicron variants, with respect to workforce absence, hospital bed capacity including critical care, the use of virtual wards, private hospitals and field hospitals, and the availability of medical equipment and appropriately trained staff to treat patients hospitalised with Covid-19.

120. As noted above, the primary aim of these contingency measures was to save lives by reducing transmission of Covid-19 and protect the NHS in Wales from being overwhelmed by demand.

121. Assessing the impact of these measures is difficult because they did not occur in isolation. Restrictions were regularly reviewed and updated and there were many changing variables and circumstances, including for example the effect of seasonable variation and wider changes in sickness rates. Data was regularly collected by Health Boards and the impact assessment considered what the transmission rates were at the time and what the data collection by Health Boards said about the current position for workforce, capacity and supplies. Throughout the pandemic, the Technical Advisory Cell and Technical Advisory Group considered the impact of the non-pharmaceutical interventions (NPIs) and the Inquiry has already considered this evidence in Module 2B. By considering this data, Ministers could decide what restrictions could be eased or tightened within the scope of the plans and frameworks noted above and what NHS services could be reduced or brought back online as needed.

122. Post-pandemic, and in November 2023, I am aware that the Welsh Government's Science Evidence Advice Division ("SEA") published a report highlighting the impact of Covid-19 protections in Wales. The report outlines an initial assessment of protections that were implemented from March 2020 to July 2022. The overall analysis identified that the Covid-19 protections in place during the pandemic were generally successful in reducing the transmission and direct impact of the virus. I exhibit a copy of this report at **M3MEM01/038 - INQ000399997[2].**

Workforce absence

123. Whilst the SEA Report did not focus exclusively on the response of the healthcare system, it reported that the self-isolation protections in the community population reduced Covid-19 infections, hospital admissions and bed occupancy compared to levels that would have been reached without such measures in place.

[2] This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000480732]

However, it also found that the self-isolation protections also increased NHS staff absence rates.

124. In terms of the impact on workforce absence, data taken from StatsWales shows that the NHS Covid-19 sickness rates by month (excluding other sickness absence reasons) between April 2020 – May 2022 (although noting my appointment commenced in May 2021) were as follows:

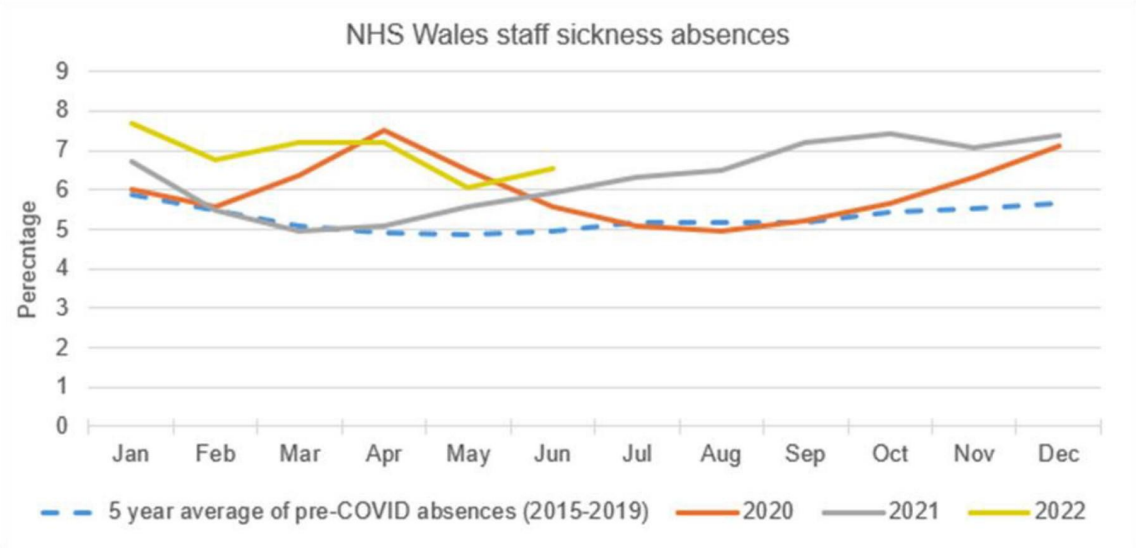
April 2020	2.4% This figure is for only part of the month. Please note that Swansea Bay UHB was unable to provide data on the same basis as others and so is excluded from the return.
May 2020	2.0% Please note that Swansea Bay UHB was unable to provide data on the same basis as others and so is excluded from the return.
June 2020	1.1%
July 2020	0.6%
August 2020	0.4%
September 2020	0.5%
October 2020	0.6%
November 2020	1.2%
December 2020	1.8%
January 2021	1.7%
February 2021	1.1%
March 2021	0.7%
April 2021	0.5%
May 2021	0.4%
June 2021	0.4%

July 2021	0.4%
August 2021	0.4%
September 2021	0.9%
October 2021	1.0%
November 2021	0.8%
December 2021	0.8%
January 2022	1.9%
February 2022	1.3%
March 2022	1.6%
April 2022	1.8%
May 2022	1.0%

125. The graph below compares the 5-year average of pre-Covid-19 NHS Wales staff sickness absences with Covid-19 years. This graph has been prepared by the Welsh Government's Knowledge and Analytical Services, utilising data taken from StatsWales. In pre-Covid-19 years, sickness absences averaged between 5% to 6%. In the following Covid-19 years, sickness absences reached above 7%, peaking at over 12% during the first wave, prior to my appointment as Minister for Health and Social Services. As to absences due to self-isolation specifically, the SEA Report found that such absences generally decreased over time. In April 2020, 40% of all staff absences were due to self-isolation whilst, by May 2022, this had reduced to just 8%, which reflected changes in the NPI measures in place during the pandemic.

126. I particularly recall that the issue of staff absences in the ambulance service was a concern during my tenure. I have detailed further below the actions I took in respect of this issue. However, ambulance staff absences as a distinct group were particularly high during the period July 2021 to March 2022. Absence rates ranged from 11.3% in July to September 2021 to 12.7% in October to December

2021, and peaked at 13.5% in the period January to March 2022. Such rates reduced to 9.7% during April to June 2022.



127. Overall, this data shows that staff absences remained well below what I recall was the worst-case scenario of 30% staff absences of which I was alerted in January 2022 that we needed to prepare for. I exhibit an excerpt from my notebook in which I noted this figure at pp.105 and 109, at **M3MEM01/039 - INQ000327588**. I recall at that time that we were very concerned about the rapidity of the spread of Delta and, more significantly, Omicron. As most people were vaccinated by this point, our concern was particularly over the volume of staff who may be absent at the same time (rather than the seriousness of staff sickness) due to the pressure this would put upon the ability of the NHS to provide essential services. Fortunately, and as may be seen, the worst-case scenario did not come to fruition.

Hospital bed capacity and use of private hospitals and field hospitals

128. I am aware that Andrew Goodall has provided evidence on NHS capacity throughout the relevant period in his statement to the Inquiry (M3/WGO/01) at paragraph 408 onwards and so I refer the Inquiry to that evidence. Insofar as the use of private hospitals and field hospitals, Andrew Goodall deals with such matters at paragraph 455 onwards. The creation and set-up of field hospitals predated my appointment, as did the commissioning of additional private sector

capacity. To the extent to which I am able, I have detailed my knowledge regarding such matters, including critical care capacity, during my tenure further below. As detailed further above, and as a general point on the impact of the aforementioned contingency measures, I note that the SEA Report found that the relevant measures put in place overall prevented greater volumes of people being admitted to hospital for Covid-19 treatment.

129. On 20 July 2021, I received advice asking me to agree that officials could confirm allocation of further NHS Covid-response funding to NHS organisations for 2021-2022. Such funding included a further £118m, based on estimates, to support Local Health Boards and Trusts to enable them to maintain local surge capacity plans for the full year. I duly agreed and a copy of the advice is exhibited at **M3MEM01/039a – INQ000103980**.

130. However, all other key Ministerial decisions pertaining to the use of private hospitals and field hospitals occurred prior to my appointment in May 2021.

The availability of medical equipment and appropriately trained staff to treat patients hospitalised with Covid-19

131. Once more, I am aware that Andrew Goodall has provided substantive evidence upon the availability of medical equipment and appropriately trained staff to treat patients hospitalised with Covid-19 in his statement, at paragraphs 370 onwards. As may be seen in that statement, the NHS and the Health and Social Services Group worked together on securing medical equipment during the pandemic. This involved the Welsh Government seeking a baseline position from the NHS in Wales and utilising modelling data and data returns (co-ordinated by the Welsh Government's Knowledge and Analytical Services with input from the NHS in Wales) to enable the sourcing of additional equipment to ensure there were no substantial issues in relation to ventilator availability. The procurement of equipment was undertaken by NHS Wales Shared Services Partnership. These processes occurred prior to my appointment as Minister for Health and Social Services and, to the extent to which there was Ministerial involvement, this has been outlined in the statement of Vaughan Gething as the Minister for Health and Social Services at the relevant time. Insofar as the availability of appropriately

trained staff, by the time I was appointed in May 2021, the data on available critical care beds reported by the Local Health Boards referred to only those beds that could be staffed.

Notification of Capacity

132. During the relevant period prior to May 2021, and before I was appointed as Minister for Health and Social Services, my knowledge of intensive care capacity was limited to that in respect of which updates were provided to Cabinet by Vaughan Gething, then-Minister for Health and Social Services. I understand that the specifics of this period have been outlined in the Module 3 statement of Vaughan Gething from paragraph 183. I do not recall being made aware at any point during this initial period that intensive care capacity had been reached or was likely to be reached imminently.

133. From May 2021 onwards, and upon being appointed Minister for Health and Social Services, I was provided with 'NHS Covid updates' by e-mail (alongside the weekly briefings at the Covid Update meetings already mentioned above). These e-mail updates included, amongst other matters, a table setting out the number of critical care beds available and how many of those were occupied by Covid-19 and non-Covid-19 patients, along with confirmation of the number of critical care beds remaining unoccupied (in numerical and percentage form) and how this compared to one day and seven days prior. I exhibit at **M3MEM01/040 – INQ000361771** an example of one such update sent to me on 6 August 2021, which is representative in format of those I received each day.

134. In addition, I also received regular 'latest figures' updates by e-mail which included a section on hospital admissions and bed capacity, including those in critical care beds. Such updates included reference to how the relevant occupancy of both standard and critical care beds compared to 'normal available capacity' pre-Covid-19, following a request made by Vaughan Gething during his time as Minister for Health and Social Services. Accordingly, and whilst such updates reference numbers as being above 'normal available capacity', this 'normal' does not account for the additional bed capacity put in place to deal with the pandemic response.

135. By way of example of what this meant for capacity in practice, I exhibit at **M3MEM01/041 – INQ000479977** an update received on 15 June 2021, which confirms that as of 14 June 2021 there were 161 patients in critical care beds which was 9 above the 'normal available capacity'; such figures largely reflecting non-Covid-19 demand with only one confirmed Covid-19 related critical care bed occupancy. As can be seen from the 'NHS Covid update' for 16 June 2021 (exhibited at **M3MEM01/042 – INQ000479978**), occupancy had slightly reduced to 156 patients (which was still 4 above 'normal available capacity), but which only constituted 72% of overall critical care bed capacity at that time.

136. Where there were notable matters arising in specific Local Health Board areas or hospitals, whether Covid-19 or non-Covid-19 related, this information was also set out in these updates. By way of example, I exhibit at **M3MEM01/043 – INQ000479984** an update received on 8 July 2021 which detailed the concerning increase in drug overdose-related admissions to Morriston Hospital during the preceding week.

137. On occasion, when receiving these updates, if there was anything that I considered required further explanation and / or attention, I would request that such matters be tabled for discussion. For example, on 21 May 2021, I received an update that confirmed that NHS pressures were improved from earlier in the week and that the number of level 4 sites had decreased to 3 (of 20 across Wales the previous day). Given the pressures on the NHS and the extent of the waiting list at that time, on 23 May 2021, I sought further understanding as to how the levels were being reduced when the situation remained at that level. I asked for this issue to be added to the agenda during my next meeting with Andrew Goodall.

138. Later that day, Andrew Goodall confirmed this issue had been added to the agenda and asked for officials to prepare a summary of the operational levels and framework for my attention, as well as confirming that the escalation levels were operational hourly and daily based upon how hospitals were managing immediate and emergency pressures, rather than a reflection of waiting list pressures or other performance priorities. I exhibit the e-mail chain reflecting this discussion at **M3MEM01/043a – INQ000361765**.

139. Whilst occupation of critical care beds varied during the relevant period, to the best of my recollection, I was not made aware at any point during my time as Minister for Health and Social Services that intensive care capacity had been reached or was likely to be reached imminently across Wales as a whole. Consideration of the daily 'NHS Covid updates' referenced above suggest that the percentage of critical beds during the Autumn / Winter 2021-22 period did not exceed 87%, although such figure would have been in excess of the 'normal available capacity' had capacity not been increased in response to the pandemic.

140. Where there were concerns relating to individual Health Board areas or hospitals, I would expect these to be brought to my attention separately. The one instance where I recall such a concern arising was in relation to the neo-natal unit at Grange Hospital in December 2021. I was informed by e-mail on 16 December 2021 of a Covid-19 outbreak in the unit which increased the pressures upon the neonatal critical care capacity. Upon becoming aware of this, I requested that I be kept updated on the progression of matters and was informed later that day that contingency plans were in place for other such units in the surrounding areas to provide support where required. A copy of the email chain on 16 December 2021 is exhibited at **M3MEM01/044 – INQ000480024**.

141. Apart from the above, and to the best of my recollection, I am not aware of any other specific instances during the period that I was Minister for Health and Social Services where I was informed that critical care capacity had been reached or was likely to be reached imminently, whether in relation to Wales or any individual Health Board area or hospital. I understand that Andrew Goodall has provided an overview of the capacity numbers generally throughout the relevant period at paragraph 430 of his statement M3/WGO/01.

Delayed Transfers of Care

142. Prior to the pandemic, I am aware that data relating to Delayed Transfers of Care was collected on a monthly basis, alongside other regular healthcare data collections. As a result of the unprecedented demand on the NHS caused by the pandemic, such data collections, including those related to Delayed

Transfers of Care, were suspended in an attempt to ease the pressure upon NHS staff resources. This occurred prior to my appointment as Minister for Health and Social Services.

143. As outlined further above, health services are primarily delivered by Local Health Boards and responsibility for the discharge of patients falls under their remit. However, the Delayed Transfers of Care was an issue in respect of which I was aware during the relevant period.

144. After becoming Minister for Health and Social Services in May 2021, I raised concerns with officials about the forthcoming winter period and the ability for the system to prepare and cope, particularly insofar as Delayed Transfers of Care were concerned. Such concerns were raised in various meetings during the summer period. I exhibit at **M3MEM01/045 – INQ000479983** an e-mail trail between officials discussing those concerns I had raised in those meetings.

145. In July 2021, £25 million in recurrent funding was allocated to support the delivery of the Six Goals for Urgent and Emergency Care. Those focused on four priority areas, one of which was implementation of discharge to assess pathways intended to avoid admissions and speed up discharge to a person's usual place of residence. I exhibit at **M3MEM01/046 – INQ000480067**, the Written Statement announcing the development of the 'Six Goals' and the relevant funding. During the new term, this was developed further and ultimately resulted in the publication of '*Right Care, Right Place, First Time*', which I have already detailed at paragraph 94 above.

146. In October 2021, I published the Health and Social Care Winter Plan for 2021 to 2022, which I now exhibit at **M3MEM01/047 – INQ000480015**. I further exhibit the Oral Statement to Senedd prior to its publication at **M3MEM01/048 – INQ000480010**.

147. It was recognised that there was some restriction in hospital flow, partly as a result of the challenges that were being experienced in terms of discharging patients when they were ready to leave. In an attempt to tackle this issue, and as

confirmed in the Winter Plan, the Welsh Government had developed a range of guidance (some in conjunction with Public Health Wales) on matters including the safe discharge from hospital services. Reference was also made to the allocation of funding to support the implementation of Discharge to Recover then Assess (D2RA) pathways through Regional Partnership Boards (who had been allocated around £144m per year to work with local authorities to address this and other issues, later becoming the Health and Social Care Regional Integration Fund). In addition, regular monthly meetings took place between me and representatives from local authorities and Health Boards to deliver a package of support to speed up the discharge of patients from hospital.

148. Delayed Transfers of Care were discussed at a Care Action Committee meeting on 11 November 2021. At this meeting, the single item on the agenda was the discussion of the potential use of capacity in residential care to assist with the challenges to hospital flow. It was noted that choice was a significant factor impacting upon discharges into residential care, along with staffing issues (that were causing some homes to partly close), funding and guidance on admissions.

149. Reports at the meeting confirmed that work was being undertaken with local authorities and Health Boards in an attempt to address the issues. I stated my desire to have a named person at local authority / NHS level who would be able to be contacted in relation to discharges. I was particularly keen to have these issues considered at a granular level. At the conclusion of the meeting, several actions were raised including the creation of a status report of the Delayed Transfers of Care system to set out what was occurring at a local / regional level by reference to the numbers of those delayed and the reasons, care home capacity and available beds, and reablement and the domestic care capacity. I have exhibited the minutes of this meeting at **M3MEM01/049 – INQ000480017**.

150. An update on this issue was received at the next Care Action Committee meeting on 18 November 2021, the minutes of which I exhibit at **M3MEM01/050 – INQ000480045**. This identified three specific areas of challenge to discharges

into care facilities: the traction to get people from hospital and into empty care homes was slow, staffing pressures precluded the ability to take on new cases and partnership working required some further improvement to ensure good communication about individuals and provision of sufficient wraparound community services where required to support higher-need individuals. Once more, various actions were raised for those present to take forward and I requested that the situation continued to be monitored by officials on a weekly basis.

151. Ahead of a press conference scheduled for mid-November 2021, I raised a query with officials about the collection of data relating to Delayed Transfers of Care and was informed that, at that time, weekly delayed discharge data was being collected by the NHS Delivery Unit to assist with management information to support new arrangements under the Discharge to Recover then Assess (D2RA) approach. At that stage, such data collection did not provide the level of detail that had been available pre-pandemic, although the intention was to shortly reinstate formal data collection, as aligned to the D2RA pathways. I exhibit an e-mail trail dated 15 November 2021 outlining this at **M3MEM01/051 – INQ000480018**. I understand that publication of such data recommenced in January 2022.

152. On 30 January 2022, I requested that data relating to how many patients were in hospital as a result of delayed transfer of care be added to the daily NHS Covid updates I was receiving. As a result, the updates provided to Cabinet on a weekly basis began to include information regarding those patients who were medically fit for discharge and the reasons for the hold up of discharge. Data setting out the total number of patients awaiting next stage of care was also provided. An e-mail trail exhibiting the request made and an example of the data available appears at **M3MEM01/052 – INQ000480037**.

153. On 10 February 2022, I gave evidence to the Health and Social Care Committee as part of their investigation into the impact of the waiting times backlog on people in Wales. Whilst I was there to give evidence primarily on the impact of the waiting times backlog on people in Wales waiting for diagnosis or treatment, the significant impact of delayed transfer of care arose in relation to its

effect upon planned care surgical activity rates. I exhibit a transcript of the Evidence Session at **M3MEM01/053 – INQ000088012**. At 12:48:52, I confirmed to the Committee that the Welsh Government was committed to putting significant effort in to assisting with this issue. This included a commitment to the Real Living Wage for the care sector, additional recognition payments for social care workers and efforts to increase recruitment in the sector, in order to deal with the impact of staff shortages upon delayed transfers of care.

154. I also instigated fortnightly meetings with the leader of the Welsh Local Government Association and other leaders to address this issue of Delayed Transfers of Care. This led to the introduction of additional bed capacity in the community of around 730 beds over winter. This was not an insignificant number in the context of the approximately 9,000 beds in the system.

155. In addition to this, my requests for further data in late-January 2022 as set out above resulted in the introduction of a national data system which categorised a reason for each Delayed Transfer of Care. As a result, we could focus in on the areas which were causing the largest challenge. This data collection was replaced by the Pathway of Care Delays in April 2023, which identifies patients with a discharge delay, and the reason for the delay, at a given point each month. It is reported by reference to Local Health Board provider, local authority of residence and by reason for delay and date.

156. On 28 March 2022, I updated Cabinet upon the forthcoming programme for transforming and modernising planned health care in Wales and for reducing waiting lists, whilst continuing to deal with Covid-19. In so doing, the existing presence of Covid-19 patients in hospital was also outlined, along with the need to continue addressing delayed transfers of care. I exhibit the Cabinet minutes at **M3MEM01/054 – INQ000022575**.

157. To the extent to which the Inquiry asks about information on the relationship between Delayed Transfers of Care and rates of nosocomial infection, I do not recall receiving anything on this specifically. There were ongoing discussions and an understanding that to address the issue of Delayed

Transfers of Care, there was a need to address the issue of care in the community. We were aware that despite the introduction of the Real Living Wage, there was still an issue of recruitment in relation to carers.

158. In particular, the pandemic coincided with Brexit and there was a resultant impact on the number of care workers from Eastern Europe living in Wales, with some leaving and others not arriving to replace them. Many workers from Eastern Europe were also working in the hospitality sector and, again, many of these people returned to their home countries while the flow of new recruits from the EU slowed. Some care workers moved to work in hospitality or retail to fill these vacant spots, leaving fewer care workers. In response to this, we introduced an active recruitment campaign (We Care Wales) to try and attract more people to work in the care sector. Whilst this was successful to a point, it did not stop the flow of care workers out of the sector.

Removal of the requirement for healthcare staff to self-isolate

159. On 14 July 2021, Cabinet agreed that fully vaccinated adults no longer had to self-isolate from 7 August 2021 if they had been identified as a close contact with a person who had tested positive for Covid-19. I previously exhibited a copy of the Cabinet minutes at **M3MEM01/002 – INQ000129973**. I further exhibit a copy of the Cabinet paper at **M3MEM01/055 – INQ000271721** which sets out the clinical and expert rationale supporting the decision made by Cabinet, including evidence that vaccines were effective in reducing transmission and preventing serious illness. There was also mounting evidence that the harms associated with self-isolation were increasing, such as negative impacts on physical and mental health, incomes, businesses and public services. It was considered that, in view of the vaccine efficacy, the risk of harm associated with self-isolation now outweighed the risk of harm associated with exposure to the virus. However, concerns remained over the risk of harm associated with nosocomial transmission in vulnerable settings. On the advice of Public Health Wales, Cabinet agreed that additional safeguards should be put in place before allowing health and social care staff who were fully vaccinated and identified as a close contact to return to work with those who were vulnerable.

160. In a Ministerial Advice dated 29 July 2021, I confirmed the decision around self-isolation requirements for contacts of confirmed Covid-19 cases made by Cabinet and I exhibit a copy of the Ministerial Advice at **M3MEM01/056 – INQ000103982**. As part of that Ministerial Advice, I was advised that officials had been working closely with the health and social care sector to develop operational guidance to allow those members of staff who were fully vaccinated to return to work in extremis circumstances, and that further advice would follow. I exhibit a press release dated 29 July 2021 at **M3MEM01/057 - INQ000479997** which notes, whilst all adults who had been fully vaccinated would no longer have to self-isolate if they were identified as close contacts of someone with coronavirus from 7 August 2021, additional safeguards would be put in place for those working with vulnerable people. As confirmed in the exhibited advice and press statement, along with a Written Statement I published on 29 July 2021 (exhibited at **M3MEM01/057a – INQ000492875**), those additional safeguards included:

a. A risk assessment for staff working in health and social care;
b. Daily lateral flow tests;
c. Strong advice to members of the public not to visit hospitals and care homes for 10 days;
d. Advice to everyone identified as a contact of a positive case to have a PCR test on days two and eight, whether fully vaccinated or not;
e. Further work to thereafter be carried out by officials to assist with additional safeguards and further advice to follow (which I detail immediately below).

161. On 30 July 2021, I was presented with further Ministerial Advice which I exhibit at **M3MEM01/058 – INQ000103984**. The Ministerial Advice recommended that operational guidance was issued setting out scheme criteria to allow health and social care workers to return to work. The scheme only applied to fully vaccinated individuals, who had received a negative PCR test and who agreed to take part in a serial testing scheme with daily lateral flow testing for 10 days. The exemption would not apply if they had been identified as a household contact of a positive case, as in these cases the degree of contact would mean that the risk of transmission would be greater. In addition, employers would need to conduct careful local risk assessment balancing the harm due to non-delivery of health and care services with the potential risk of transmission of Covid-19. The scheme was

supported by advice from Public Health Wales dated 22 July 2021 and exhibited at **M3MEM01/059 – INQ000056317**[3], which recommended that individuals who were essential to the functioning of a critical area of service delivery, were fully vaccinated and had good access to testing and advice, could be considered for exemption from self-isolation where they were advised that they were a contact of a case, with mitigation by serial testing.

162. In terms of timings, the Ministerial Advice recommended that the operational guidance was implemented before 7 August 2021 to enable essential health and social care staff, who had been identified as a contact with someone who had tested positive for Covid-19, to return to work in areas where there were exceptional service delivery challenges. After 7 August 2021, the same risk assessment and mitigation processes would remain in place to act as additional safeguards in settings where individuals worked with vulnerable people. I agreed the Ministerial Advice, but due to delays in the wording of the guidance, the operational guidance was not published until 11 August 2021, a copy of which I exhibit at **M3MEM01/060 – INQ000275813**. It is unclear to me whether the NHS in Wales followed the guidance to enable staff to return to work prior to 11 August 2021.

Increase in the Welsh Government's self-isolation support scheme

163. The Welsh Government's self-isolation support scheme, which was announced by the First Minister in October 2020, was established to remove financial barriers faced by people who needed to self-isolate. The amount of the payment was an ongoing consideration to ensure that we were sufficiently supporting people to self-isolate. I exhibit a copy of a Ministerial Advice dated 29 July 2021 at **M3MEM01/061 – INQ000136886** which outlined feedback from stakeholders indicating that the £500 payment, that was in place at that time, did not cover living expenses for the 10-day isolation period, and that an increase in payment to £750 would:

a. Encourage testing and adherence with self-isolation;

[3] 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 [INQ000275814]

b. Motivate people to test and self-isolate as there would be less fear of the financial impact;
c. Cover the personal income threshold of £500 a week net income;
d. Cover the loss of a living wage income for 10 days.

164. I agreed the Ministerial Advice and on 4 August 2021, I announced that, with effect from 7 August 2021, the Welsh Government's self-isolation support scheme would increase from £500 to £750. I exhibit a copy of the press announcement at **M3MEM01/062 - INQ000480077**. The date that the increase was brought into force coincided with the date on which fully vaccinated adults who had been in close contact with a person who had tested positive for Covid-19 were exempt from self-isolation. However, the increase in payment would still have benefited those who were unvaccinated, and those people (whether vaccinated or unvaccinated) who themselves tested positive for Covid-19.

Mitigation of Impact of Omicron Variant by Vaccination Programme

165. A key aspect of the Welsh Government's Coronavirus Control Plans in protecting the public from serious illness and death from Covid-19, and thus mitigating the impact of the virus on the healthcare system in Wales, was the vaccination programme. By the end of July 2021, we had offered the vaccine to all the eligible adult population and the evidence indicated that vaccines were effective in terms of both preventing severe disease and transmission.

166. When the Omicron variant emerged, the Joint Committee on Vaccination and Immunisation provided advice on the response to the Omicron variant which I exhibit at **M3MEM01/063 – INQ000480021** which outlined that, whilst the protection of Covid-19 vaccines against the variant was unknown, the Committee considered that accelerating and expanding the vaccination programme would maximise protection for individuals ahead of a wave of infection. This included: extending the eligibility for the booster to include all adults over 18; offering the booster vaccination at a reduced minimum three months post completion of the primary course; offering severely immunosuppressed individuals who had completed their primary course a booster dose with a minimum of three months between the third dose and booster dose; ensuring that the Moderna and Pfizer-

BioNTech vaccines were used in equal preference; offering all children and young people aged 12 to 15 years a second dose of the Pfizer-BioNTech vaccine at a minimum of 12 weeks from the first dose; and reducing the interval for 12-17 year olds to at least 8 weeks between doses. I was presented with the advice of the Joint Committee on Vaccination and Immunisation in a Ministerial Advice dated 29 November 2021 which I exhibit at **M3MEM01/064 – INQ000116727**. I agreed the advice, and on the 13 December 2021 the First Minister announced that Wales would be offering all adults a Covid-19 booster vaccination by the end of 2021.

167. The decision required a significantly accelerated booster campaign which was described to the NHS in Wales in a letter from the Chief Medical Officer and the Deputy Chief Medical Officer on 30 November 2021 which I exhibit at **M3MEM01/065 – INQ000270512**[4]**.** It was clear that this would be extremely challenging, particularly given the required run-rate to achieve the targets we had already set as part of the campaign. The Covid-19 Vaccination Programme and the entire Welsh vaccination system again rose to that challenge.

168. In a Ministerial Advice dated 14 December 2021 exhibited at **M3MEM01/066 - INQ000136873,** I was advised that the evidence showed that the threat of the Omicron variant was even greater than first thought with transmissibility doubling every two days. I agreed to operationalise the advice of the Joint Committee on Vaccination and Immunisation as quickly as possible.

169. We achieved our aim, with all Local Health Boards in Wales confirming they had offered all eligible adults a booster appointment by 31 December 2021. Offers were made to anyone eligible through a range of methods including letters, texts, online booking and walk-in options. We used all available communications channels to keep people informed.

170. On 24 February 2022, I published the Covid-19 Vaccination Strategy for 2022 which I exhibit at **M3MEM01/067 – INQ000480058** which included reflections on the impact of the vaccination programme on the Omicron variant. In short, the vaccination programme had a very positive impact on the Omicron variant;

[4] 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 [INQ000388310]

scientific evidence indicated that three doses of the vaccine were between 50% and 75% effective at preventing symptomatic disease of Covid-19 with the Omicron variant within the first three months of receiving a booster vaccine, and offered higher levels of protection against severe disease including hospitalisation and death. This was borne out in what we saw in Wales where cases of coronavirus fell throughout January and February 2022, and the number of people admitted to hospital with confirmed or suspected Covid-19 and those in hospital with confirmed Covid-19 also reduced.

Sufficiency of Critical Care Capacity during Relevant Period

171. I was regularly given updates on how many patients were in critical care. By the time I was appointed as Minister for Health and Social Services the vast majority of the population had been vaccinated and therefore the numbers in critical care were lower than pre-vaccination. There was always pressure in critical care, but at no point during my tenure as Minister for Health and Social Services did I feel there was a lack of critical care capacity within the NHS in Wales.

Sufficiency of Covid-19 Tests, Medical Equipment and Medicines

172. To the best of my recollection, I was not made aware of any issues regarding the possibility of insufficient supplies of Covid-19 tests, medical equipment and / or medicines for the treatment of Covid-19 during the time that I was Minister for Health and Social Services from May 2021 onwards. Any issues prior to this date would have been brought to the attention of my predecessor, Vaughan Gething, and I would only have become aware of them to the extent to which it was necessary for Cabinet to be updated during this time.

Covid-19 Moral and Ethical Advisory Group

173. The Covid-19 Moral and Ethical Advisory Group Wales was set up in April 2020, prior to my appointment as Minister for Health and Social Services. This was set up to gather and co-ordinate issues relating to moral, ethical, cultural and faith considerations, and to provide a source of advice to public services on issues arising from the health and social care emergency response to the pandemic. It was sponsored by a number of Ministers including then-Minister for Health and Social Services, Vaughan Gething, and I understand he has dealt

with the establishment in his statement at paragraphs 231 to 241. I also understand that Andrew Goodall has detailed the remit and work of the Group in his statement at paragraphs 244 to 250.

174. I did not attend any meetings of the Covid-19 Moral and Ethical Advisory Group. I had no regular contact with the Group and understand that the advice provided generally went to the Chief Medical Officer for Wales, Frank Atherton, in the first instance.

175. In my role as Minister for Health and Social Services, I would receive guidance on various matters that I understand the Covid-19 Moral and Ethical Advisory Group was involved in considering. However, this advice did not come directly to me from the Group. For example, and on 28 July 2021, I received a report on Moral Injury in Health Care Workers during the Covid-19 Pandemic dated 27 July 2021, but this Report was authored by the Technical Advisory Group. I understand that the Covid-19 Moral and Ethical Advisory Group had produced an advisory note on the topic in July 2021, but I was not provided with a copy of that directly. I exhibit here the aforementioned Technical Advisory Group Report at **M3MEM01/068 – INQ000066119** and the covering email and my response to it at **M3MEM01/069 – INQ000479998**. In my response, I confirmed I was content for the paper to be published and requested that copies be provided to the Health Boards in Wales. I also asked officials to undertake some further work to consider how the various recommendations made would be actioned. On 3 August 2021, it was confirmed to me that the paper had been published and was visible on the Technical Advisory Cell webpages. It was also confirmed that copies had been sent to Health and Social Services Group officials and would be circulated to Health Boards shortly.

Response of Ambulance Services

176. I am asked to detail any concerns that were brought to my attention regarding the response of primary care, pharmacies and / or ambulance services specifically in relation to the Delta and / or Omicron variants.

177. On 9 June 2021, I was provided with a copy of an Interim Report from the Ministerial Ambulance Availability Taskforce ("MAAT"). This Taskforce was jointly chaired by the Chief Ambulance Services Commissioner and National Director of Emergency Medical Retrieval and Transfer Service Cymru, with membership drawn from relevant leaders across the health and social system. It had been established in January 2020 by my predecessor, Vaughan Gething, with the intent of realising necessary improvements in ambulance service delivery.

178. The Interim Report received in June 2021 made the following three recommendations:

a. To extend the Taskforce for a further 12 months;
b. To allocate additional recurrent revenue as part of a specific commissioning budget;
c. To develop financial mechanisms at the commissioner level that promote collaborative delivery of 'value based' improvements and enable risk sharing across the system.

179. Following receipt of this Report, I met with my officials to seek advice on 15 June 2021 and expressed the view that I was keen to know how we could now proceed to implement the findings from the report rather than continue for a further 12 months. I thereafter sought a meeting with the Joint Chairs of the Taskforce to better understand the issues, which took place on 24 June 2021. A copy of the e-mail thread setting out the above is exhibited at **M3MEM01/070 – INQ000479979.**

180. At that meeting, I indicated that I would like to attend the next available Emergency Ambulance Services Committee meeting to provide a clear steer to members on expectations for improvement given the existing challenges. The main challenges arose from the national target for immediately life-threatening (Red) calls having not been achieved since July 2020. Whilst Covid-19 created challenges to a timely response, there remained other factors significantly impacting ambulance availability and response timeliness. Some of the answers

to those challenges lay with the Welsh Ambulance Services Trust, whilst others required system-wide co-operation, such as ambulance patient handover delays and access to clinically safe alternatives.

181. It was agreed that the Taskforce would finish its work as a Ministerial group by the end of July 2021. I was particularly keen that a move was needed from review and diagnosis to radical and rapid focus on delivery of actions that were known to make a difference to patients. It was agreed at that meeting that the existing governance structure in place for collaborative commissioning of emergency ambulance services was well placed to enable this shift and thus the Taskforce was not required beyond this point.

182. Following that meeting, officials were asked to explore opportunities to identify a recurrent budget of £5 million, to be allocated to the Chief Ambulance Services Commissioner, from 2021/2022 onwards to enable delivery of the priorities identified by the Taskforce and the Emergency Ambulance Services Committee and to support delivery of a modern emergency ambulance service. This request was ultimately surpassed by the developments and further funding provided, as I set out below.

183. I attended a special meeting of the Emergency Ambulance Service Committee on 20 July 2021, at which I tasked the Committee to develop a time-bound action plan to describe actions to facilitate the following:

a. Deliver improved management of 999 demand in the community;
b. Increase capacity;
c. Improve responsiveness to people with time sensitive complaints;
d. Enable rapid improvement in ambulance patient handover.

184. I was also keen to ensure that timescales were brought forward to enable robust delivery over the winter period, with medium-term plans also to be accelerated to increase capacity by the recruitment of ambulance clinicians.

185. I exhibit at **M3MEM01/071 – INQ000480063** the briefing prepared by my officials prior to this meeting setting out the concerns and how it was proposed these would be addressed.

186. In September 2021, I received the first iteration of the Emergency Ambulance Services Committee delivery plan under MA/EM/3104/21, which is exhibited at **M3MEM01/072 – INQ000480062**. This identified a range of actions, which focused upon:

a. Improved forecasting to better understand and plan for actual demand and match resourcing accordingly;
b. Demand management, including Health Board clinicians directly managing ambulance patients and redirecting them to clinically safe alternatives;
c. Enhancing ambulance clinician capacity through accelerated recruitment and continued implementation of recommendations from independent demand and capacity review;
d. Improved efficiency in the utilisation of resources to better match capacity to demand; and
e. Improved local and national system-wide escalation processes.

187. On 20 September 2021, I wrote a letter in response noting the progress made and the particular importance of recruiting additional staff. Notwithstanding, there remained challenges, particularly regarding handover delays at specific hospitals and I requested further information on various aspects of the plan. Finally, I confirmed my awareness of occasions when the Welsh Ambulance Services Trust had escalated to a 'can't send' policy for certain call categories (through its Demand Management Plan) and I confirmed my expectation for Health Boards to take responsibility for their populations and provide every opportunity for a safe ambulance service, including increasing use of the Physician Triage and Assessment and the specialty advice and guidance line. I invited discussions with officials as to next steps, including whether additional support was needed. I exhibit this letter at **M3MEM01/073 – INQ000480001**.

188. On 19 November 2021, the Chief Ambulance Services Commissioner wrote to me providing an updated version of the plan, along with outlining progress and additional actions including those I had highlighted in my earlier letter. I exhibit at **M3MEM01/074 – INQ000480085** a copy of the letter and at **M3MEM01/075 - INQ000480086** the updated delivery plan received.

189. The key areas of progress identified included:

a. Enhancing ambulance capacity;
b. Implementation of safe patient 'cohorting' had commenced at Morriston Hospital, was shortly due to commence at Grange University Hospital and discussions were ongoing regarding implementation at Ysbyty Glan Clwyd;
c. A commitment from Health Boards for no ambulance patient handover to take more than 4 hours and to reduce the average lost time per arrival by 25% from the October 2021 level at each site (which equated to a reduction from 72 minutes to 54 minutes at an all-Wales level);
d. Findings from refreshed modelling of Demand and Capacity Review to reflect system changes since 2018 had been considered by the Committee and the Welsh Ambulance Services Trust had been asked to prepare an options paper for consideration by the Committee by December 2021;
e. Progress being made in each Health Board regarding Physician Triage, Assessment and Screening ("PTAS") with regular updates requested from the Welsh Ambulance Services Trust for each Health Board;
f. Recruitment underway for mental health support on the clinical support desk, with a start date scheduled for January 2022;
g. Development commenced for a national policy for direct referral of clinically appropriate ambulance patients by paramedics into local Same Day Emergency Care ("SDEC") services;
h. Increased Consultant Connect (specialist advice and guidance) activity following rollout of smartphones to approximately 85% of the Welsh Ambulance Services Trust vehicles, with further rollout ongoing;

i. Work underway to embed day to day system planning and escalation within the Welsh Ambulance Services Trust to help inform operational adjustments to improve ambulance performance.

190. Data showed that, since the plan had launched in July, there had been an improvement in the delivery of key clinical indicators, which demonstrated the following:

a. More patients had been managed in the community following remote clinical assessment;
b. More patients had been referred to alternatives in the community or had been directly admitted to hospital, avoiding or bypassing the Emergency Department;
c. Fewer patients had been transported by ambulance to hospital;
d. There was more capacity available to respond to Red / immediately life-threatened calls.

191. Unfortunately, and despite such progress having been made in accordance with the initial plan, I was also informed that the Welsh ambulance service had continued to see increased demand and a range of system-wide challenges which had reduced capacity, similarly to other ambulance services across the UK, and which had impacted on the quality and timeliness of responses to people in the community.

192. At that time, I was informed that the latest published NHS in Wales activity and performance data showed performance against the national target for Red calls in October 2021 was the worst on record since the clinical response model was introduced in October 2015, with only 50% of immediately life-threatening or Red calls receiving a response within eight minutes against a national target of 65%.

193. The median response time for Red calls was the longest on record in October 2021 and the median response time for Amber calls was the second

highest on record, being only 4 minutes shorter than the previous month when the median was the longest on record.

194. The context of these performance indicators showed that there were record levels of demand for ambulance services, with the number of calls in October 2021 reaching 43,431, an average of 1,401 calls per day, which was the fifth highest on record. An average of 132 Red calls (immediately life-threatening) per day in October 2021 was the highest since comparable Red call data was first made available in May 2019 and represented the fifth consecutive month where the average number of calls per day exceeded 100.

195. In addition to this demand, I was also informed there had been an increase in staff absence due to a combination of sickness, self-isolation, shielding and annual leave, which had limited the availability of frontline ambulance clinicians, as well as clinicians and call handlers working in the Welsh Ambulance Services Trust's clinical contact centres. Absence rates of 8.9% in June 2021 were the highest of any NHS Wales organisation in that month, with sickness absence having reached record levels in December 2020 and January 2021. It was anticipated that winter 2021/22 could see similar levels. As already detailed above, these projections were borne out and increased upon with absence levels for ambulance staff reaching 13.5% in the first quarter of 2022.

196. There continued to be a need for ongoing compliance with practical Covid-19 infection prevention and control requirements, such as the use of personal protective equipment and deep cleaning of equipment and vehicles for each response, which impacted on ambulance availability and responsiveness at times of peak demand. Ambulance availability was also being significantly impacted by increasing handover delays, with such delays in October 2021 being 12% more than the previous highest total recorded in August 2021.

197. I was informed that the challenges were expected to continue and exacerbate as we proceeded into winter, which required immediate action to improve resilience, increase capacity and mitigate system-wide risks to patient outcomes and staff and patient experience.

198. In the updated delivery plan, the Emergency Ambulance Services Committee and the Welsh Ambulance Services Trust had proposed a small number of targeted opportunities to invest in ambulance services to enhance capacity and improve resilience over the winter period, including:

a. Investment in additional front line ambulance staff in line with the independent demand and capacity review;
b. Increase of clinical support desk staffing and new Emergency Medical Technicians;
c. Additional capacity to support winter response including Non-Emergency Patient Transport Services and agency transfer vehicles to support planned and urgent care, and a Private Emergency Medical Service vehicle and staff dedicated for high acuity inter-hospital transfers;
d. Extension and continuation of the Operational Delivery Unit, whilst the commission approach for local Units was developed;
e. Support for the Make Ready Depot at Singleton to allow for increased vehicle availability in the Swansea Bay area, with longer-term suitable plans being developed as part of a wider estates strategy;
f. Delivery of a respiratory project via the appointment of a clinical specialist within the Welsh Ambulance Services Trust to improve respiratory patient management.

199. Accordingly, and on the same date as receiving the updated plan, a further Ministerial Advice (MA/EM/3960/21) was submitted to me, a copy of which I exhibit at **M3MEM01/076 – INQ000176870** which requested the allocation of £5 million in non-recurrent revenue funding to the Welsh Ambulance Services NHS Trust in 2021/22 to support the implementation of the Emergency Ambulance Services Committee delivery plan and enhance capacity over the forthcoming winter period. I agreed this funding on 22 November 2021, a copy of which is exhibited at **M3MEM01/077 – INQ000480019**.

200. It was confirmed that I would continue to receive monthly updates on progress against the delivery plan. There continued to be monthly updates to the

plan submitted by the Emergency Ambulance Services Committee and I held monthly meetings with the Welsh Ambulance Services Trust and the Chair of the Emergency Ambulance Services Committee.

201. At the same time, and alongside the steps being taken to improve capacity and responses of the ambulance services internally, steps were also being taken to provide support from external resources. On 22 September 2021, the First Minister and I were requested to agree to the seeking of military support to provide 251 drivers with a C1 driving licence to support the Welsh Ambulance Services Trust to meet current and forecast demands over the period 15 October 2021 to 31 March 2022, which equated to an additional 42 emergency ambulance crews across the week. I exhibit the Military Aid to the Civil Authorities ("MACA") request and accompanying annex at **M3MEM01/078 – INQ000480061** and **M3MEM01/079 – INQ000480059** respectively.

202. In response to this request, I requested details of the proposed costs of providing this support, along with further information as to the reasoning for the level of support being requested. This was provided on 22 September 2021, and is exhibited at **M3MEM01/080 – INQ000480003.**

203. Having considered this, I confirmed that I was content to agree the request, as was the First Minister, subject to confirmation of the costs. I exhibit the e-mail chain setting out the provision of the original request and my agreement thereto at **M3MEM01/081 – INQ000480006**.

204. On 24 September 2021, Andrew Goodall provided an update on the progression of this request for support, with the number of drivers to be provided estimated as being closer to 100 military personnel, along with detail upon the corresponding reduction in costs from the earlier estimates provided. I exhibit a copy of Andrew Goodall's e-mail at **M3MEM01/082 – INQ000480005**. I understand that, following this first Military Aid to the Civil Authorities request, 110 drivers were provided for a duration of six weeks until the end of November 2021.

205. On 17 November 2021, the First Minister and I were asked to agree a further request for the seeking of military support to provide 251 drivers with a C1 driving licence to support the Welsh Ambulance Services Trust to meet current and forecast demands until 31 March 2022, which equated to an additional 42 emergency ambulance crews across the week. I exhibit the second Military Aid to the Civil Authorities request and accompanying annex at **M3MEM01/083 – INQ000480066** and **M3MEM01/084 – INQ000480008** respectively.

206. At the time of this further request, I was informed that data since deployment of the military support previously approved had reduced community-based patient waiting time and improved emergency ambulance production by up to 10%. However, hospital handover delays continued to deteriorate due to whole system pressures and significant Health Board staffing issues. The request further outlined the impact this had upon modelling previously carried out and the additional alternative actions being taken by the Welsh Ambulance Service Trust to reduce patient waiting times alongside.

207. I agreed this request and, on 15 December 2021, was informed that formal confirmation of authorisation for the extension and uplift of Military Aid to the Civil Authorities support to the Welsh Ambulance Services Trust of 251 drivers until 31 March 2022. This was to include the existing deployment of 100 allocated drivers remaining on task, until the deployment of an additional 151 drivers and support personnel starting on 5 January 2022 for training and employment. I exhibit the e-mail confirmation at **M3MEM01/085 – INQ000480025**.

Response of Primary Care and Pharmacies

208. During the relevant period, and after my appointment in May 2021, I recall receiving several pieces of correspondence requesting clarification about the continued use by GPs of remote consultations, particularly following the announcement on behalf of the UK Government that it would be returning to in-person appointments. Such correspondence came either from my own constituents writing to me in my capacity as a Member of Senedd and / or from members of the Welsh public generally writing to me in my capacity as Minister

for Health and Social Services. Such correspondence varied as it usually included reference to individual experiences. However, a common thread was that they generally sought clarification as to whether Welsh GPs would be returning to in-person appointments as standard, or whether remote consultations would continue.

209. GP practices had quickly adapted during the initial phase of managing the pandemic to adopt a total triage way of working, which included learning how to make best use of video consultations or telephone consultations in delivering patient care where appropriate, and offering face-to-face appointments when deemed clinically necessary by the GP. As the pandemic progressed, and as detailed elsewhere in this statement, the approach taken was to retain digital consultations as a significant feature of how patients were to be treated. This would not only allow access to timely and convenient appointments without patients needing to leave their homes, but also permitted appointments to be provided by a range of practice staff who could support individual needs such as physiotherapists, pharmacists, GPs and practice nurses. In ensuring that such services were effective, a joint letter from the Welsh Government, NHS Wales, General Practitioners Committee Wales and Royal College of General Practitioners Wales had been issued to the GP profession on 16 July 2021 setting out the expectations on GPs including ensuring good communication with patients, offering digital services and continuing with effective triage.

210. Where such correspondence was received by my office, responses were generally provided by the Health and Social Services Group setting out the resources available including the Welsh Government's 'Help Us Help You' campaign. As the implementation of health services at a local level is the responsibility of the relevant Local Health Boards, resources and points of communication to assist with the resolution of any concerns about arrangements at individual GP surgeries were also routinely provided. By way of example, I exhibit one such response at **M3MEM01/086 - INQ000480734**.

211. To the best of my recollection, I do not recall receiving any concerns during the time that I was Minister for Health and Social Services in the relevant period regarding the response of pharmacies during the Delta or Omicron waves.

Telephone Triage Services

212. I am asked to detail any issues regarding the capacity or operation of telephone triage services, such as 111 or Covid-19 Clinical Assessment Service, that were brought to my attention during the relevant period. Insofar as the Covid-19 Clinical Assessment Service is concerned, this was a service set up in England only and was not available in Wales.

213. As set out in paragraph 86 of Andrew Goodall's statement (M3/WGO/01), the NHS 111 Wales service was (and continues to be) provided by the Welsh Ambulance Services Trust. During the pandemic, this service was not nationally available although it was expanded to provide national coverage across the whole of Wales on or around 16 March 2022.

214. By the time I was appointed as Minister for Health and Social Services in May 2021, I understand that the Welsh Government was receiving daily returns from the NHS 111 Programme team, albeit only in respect of those NHS organisations that had implemented the service in their area. However, as these returns consisted solely of operational data, they would not have been provided to me directly.

215. Whilst the management and expansion of capacity of the NHS 111 Wales Programme was the responsibility of the Welsh Ambulance Services Trust, paragraphs 450 to 454 of Andrew Goodall's statement (M3/WGO/01) sets out the actions taken by the Welsh Government, prior to my appointment as Minister for Health and Social Services. This included encouraging Health Boards to develop 'contact / telephone first' services at the outset of the pandemic, with such plans later developing into the provision of remote hubs for many of the Health Boards in Wales.

Increased Use of Technology

216. I am not aware of any specific concerns brought to my attention about the increased use of technology by GPs, although the Older Persons Commissioner did have some concerns about the impact on elderly people who found difficulty using technology. I am aware that the Older Persons Commissioner consequently prepared a report on such matters in November 2021 entitled '*Ensuring access to information and services in a digital age: Guidance for Local Authorities and Health Boards'*. This report set out various actions required by local authorities and Health Boards to ensure older patients could access information and services and were not being digitally excluded.

217. Paragraphs 642-657 of Andrew Goodall's WGO-01 module 3 statement to the Inquiry describes the use of technology in Wales during the pandemic, including the work of the Health and Social Services Group, Covid-19 Digital Cell and Digital Communities Wales to support those at risk of digital exclusion and provide people with digital skills and confidence.

<u>£100m investment to kickstart the health and care system's recovery</u>

218. In March 2021, the Welsh Government published "*Health and Social Care in Wales – Covid-19: Looking forward*" which I previously exhibited at **M3MEM01/021 - INQ000066129**. This document acknowledges the significant impact that the Covid-19 pandemic had on the health and social care system in Wales, sets out lessons learnt from the pandemic, and provides high level direction from the Welsh Government about how the health and social care sector in Wales would drive forward its recovery and planning following the Covid-19 pandemic. Broad principles of recovery for the whole of the NHS included: reducing health inequalities to achieve a fairer Wales; building a more responsible primary and community care; creating supportive mental health services; more effective and efficient hospital services; better working between health and social services; supporting and building a resilient workforce; and providing accessible digital support.

219. To support the recovery of the health and social care system in Wales, in accordance with the principles of "*Health and Social Care in Wales – Covid-19:*

Looking Forward" my predecessor, Vaughan Gething, agreed to invest £100 million in the NHS in Wales. This funding came from capital within the Health and Social Services Main Expenditure Group and was non-recurrent. A copy of the Ministerial Advice dated 19 March 2021 agreed by Vaughan Gething has previously been exhibited at **M3MEM01/012 – INQ000116613**.

220. When I was appointed Minister for Health and Social Services, I was responsible for allocating the £100m investment and on 20 May 2021 I set out plans as to how the investment would be allocated amongst the NHS in Wales. I previously exhibited the press release dated 20 May 2021 at **M3MEM01/013 - INQ000283275** which confirmed that I allocated:

a. £13m to Cardiff and Vale University Health Board to increase capacity for a range of therapies and diagnostics, including staff recruitment and two new mobile theatres;
b. £2.5m to Powys University Health Board to transform patient services and increase capacity for a range of services;
c. £16m to Cwm Taf Morgannwg University Health Board for recruitment and investment in surgical and diagnostic capacity;
d. £13m to Hywel Dda University Health Board to improve capacity for planned care, including hospital redesign, investment in diagnostics;
e. £17m to Aneurin Bevan University Health Board for projects to increase capacity in planned care, diagnostics, therapies and mental health;
f. £16m to Swansea Bay University Health Board to increase capacity in a wide range of areas, including theatres, recruitment and ophthalmology;
g. £20m to Betsi Cadwaldr University Health Board to increase capacity in planned care, cancer, dental, diagnostics and endoscopy; and
h. £2.5m to Velindre University NHS Trust to increase capacity in radiotherapy.

<u>£551m investment for health and care services</u>

221. On 20 July 2021, I was presented with Ministerial Advice which I exhibit at **M3MEM01/039a – INQ000103980.** As set out in the Ministerial Advice, whilst there was funding allocated to support ongoing costs of dealing with the Covid-19 pandemic for the first six months of the financial year 2021-22, an additional £411m was required

from the reserves to the Health and Social Services Main Expenditure Group for the second six months of the financial year 2021-22. This was in view of updated NHS forecasts for the costs associated with: local capacity plans; the shortfall in 2020-2021 savings; contract tracing; testing costs; vaccination programme; PPE; cleaning standards; social care packages; extended flu programme; and other Covid-19 response measures such as ongoing communication programmes.

222. On the same day I was also presented with additional Ministerial Advice which I exhibited previously at **M3MEM01/011 – INQ000103981.** This Ministerial Advice indicated that a further £100m revenue funding was required to support the NHS to access additional capacity to reduce waiting lists and a further £40m capital funding was required to undertake changes to the NHS estate to enable routine care activity to increase. This was in addition to the £100m investment already allocated to the NHS in May 2021 to support its recovery.

223. Both myself and the Minister for Finance and Local Government agreed both Ministerial Advice submissions, and on 19 August 2021 I announced the allocation of the £551m of extra funding for health and social services, comprising £411m for ongoing costs of dealing with the pandemic until April 2022 and £140m for recovery and tackling waiting times. I exhibit a copy of the announcement at **M3MEM01/088 - INQ000480065**.

224. Details regarding the allocation of the £140m is set out in Ministerial Advice dated 17 September 2021 previously exhibited at **M3MEM01/014 – INQ000145144** which includes an emphasis on taking steps to address the backlog of patients awaiting diagnostic tests and treatment including service transformation and maximising workforce availability and treatment and diagnostic capacity. I felt that this was extremely important in view of the potentially devastating impact that delays to testing and treatment could have on patients.

<u>£34m of extra funding to support the Welsh Ambulance Services Trust</u>

225. On 23 December 2021 I announced £34m of additional funding to support the Welsh Ambulance Services Trust through the winter of 2021. I exhibit a copy of my announcement at **M3MEM01/089 - INQ000480073**. This was comprised of:

a. £11m to extend military support for ambulances until the end of March 2022 as a result of the increase in personnel from 100 to 250;
b. £15m to fund the replacement of 111 emergency vehicles to improve fleet reliability and availability, which included 39 replacement emergency ambulances, 12 new emergency ambulances and 23 rapid response vehicles;
c. £8m to support emergency ambulance services, and non-emergency patient transport services.

226. I have already detailed at length earlier in this statement, the military aid sought in view of the demands on the Welsh Ambulance Services NHS Trust and forecasted winter pressures in late-2021 to March 2022. These requests were agreed by me, the First Minister and the Secretary of State for Wales.

227. As regards the £15m to fund the 111 emergency vehicles, prior to my appointment as Minister for Health and Social Services, Vaughan Gething had endorsed the Welsh Ambulance Services Trust Fleet Replacement Strategic Outline Programme. I exhibit a copy of the Ministerial Advice approving the Strategic Outline Programme at **M3MEM01/090 – INQ000480733** which detailed the vision for the fleet department of Welsh Ambulance Services Trust for a ten-year period commencing in 2018.

228. In Ministerial Advice dated 15 December 2021 and exhibited at **M3MEM01/091 – INQ000480072** I was advised that the Welsh Ambulance Services NHS Trust had submitted a Vehicle Replacements Business Justification Case requiring a capital investment of £15.175m for the financial year 2022-2023 for the purchase of 111 operational vehicles representing delivery of year five as outlined in the Strategic Outline Programme. The costs and numbers in the Business Justification Case were slightly different from the numbers quoted within the Strategic Outline Programme due to the Trust looking at lower carbon options, the significant price increases being seen and also a reassessment of the equipping of emergency responding vehicles. I agreed the capital investment.

229. As regards the £8m to support emergency ambulance services and non-emergency patient services, this included the £5m of non-recurrent revenue funding to the Welsh Ambulance Services Trust in 2021/22 to support implementation of the Emergency Ambulance Services Committee delivery plan that I have already detailed in paragraph 199 above.

230. The remaining £3m was allocated towards non-emergency transport services and the recruitment of mental health practitioners to support people with mental health issues over the phone, and funding to support mental health patients through a transport pilot delivered by St John Cymru Wales.

Part E: Infection Prevention and Control

Nosocomial Infections

231. During the relevant period, Public Health Wales collated surveillance data on probable and definite nosocomial Covid-19 infections in Wales. I was notified of national figures and trends identified by Public Health Wales via ad hoc briefings sent to me by officials in the Health and Social Services Group. By way of example of such briefings I exhibit:

a. A briefing sent to me on 30 June 2021 at **M3MEM01/092 - INQ000479982** which outlined that Public Health Wales data for 1 March 2020 – 30 May 2021 indicated 7127 probable and definite nosocomial Covid-19 infections in Welsh hospitals.
b. A briefing sent to me on 20 September 2021 by the Deputy Chief Medical Officer at **M3MEM01/093 – INQ000480002** sharing a report prepared by Public Health Wales on the contribution of nosocomial transmission cases to overall hospital Covid-19 cases during the third wave. This report was particularly helpful as it provided a graph showing the weekly number of probable and definite hospital onset confirmed cases across Wales between March 2020 and September 2021.
c. A briefing sent to me on 13 May 2022 at **M3MEM01/094 – INQ000480040** sharing two reports prepared by Public Health Wales. The first report,

'*Mortality in Nosocomial Covid-19 in Wales*', which I exhibit at **M3MEM01/095 – INQ000276011**[5], looked at data from 9000 patients with nosocomial Covid-19 and found that the rate of mortality from all causes approximately one month after diagnosis for those patients who caught Covid-19 in hospital was consistent with the rate in those patients in hospital who had caught Covid-19 in the community. The second report, '*Nosocomial Covid-19 in Wales: Lessons Learned from Hospital Outbreaks, September 2020 – April 2021*', which I exhibit at **M3MEM01/096 – INQ000480043**, looked at the second wave of the pandemic and reviewed the implementation of lessons learned in the first wave. It demonstrated the importance of rapid review and learning to support ongoing safe and effective care.

232. I was particularly interested to understand whether there were any differences in nosocomial transmission rates between Local Health Boards in Wales and also for confirmation as to whether hospital acquired infection broadly reflected infection within communities. I exhibit an email that I sent on 16 November 2021 asking for a breakdown of figures at **M3MEM01/097 – INQ000480033.** As set out in the email exchange, I was provided with further information from the Deputy Chief Medical Officer who confirmed that the data from Public Health Wales showed a close correlation between community and hospital transmission rates in most Local Health Boards, with the exception of Cardiff where the association was much less strong.

233. Minimising nosocomial transmission was a key priority throughout the pandemic in both health and social care settings. The primary way in which the Welsh Government attempted to reduce the risk and impact of nosocomial infections was by way of infection and prevention control measures. In May 2020, the Welsh Government established the Nosocomial Transmission Group which was jointly chaired by the Deputy Chief Medical Officer for Wales and the Chief Nursing Officer for Wales. My predecessor, Vaughan Gething, has detailed the set-up and remit of this group at paragraphs 250-253 of his statement. The group acted as a forum for review of core

[5] 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 [INQ000480042]

Covid-19 data streams concerning hospitals and care homes and was instrumental in developing an extensive range of advice and guidance for the NHS in Wales on implementing infection prevention and control guidelines, PPE, Covid-19 testing, cleaning standards, bed spacing, ventilation and environmental controls.

234. When I was appointed as Minister for Health and Social Services, the Nosocomial Transmission Group was very well established and would meet on a monthly basis. I was aware of the work they did in helping to reduce the risk and impact of nosocomial infections, as indicated in the briefing exhibited earlier at **M3MEM01/093 – INQ000480002**. I was assured that there was strong adherence to the guidance issued by the Nosocomial Transmission Group, and that ongoing measures were in place to help prevent and reduce the risk of nosocomial transmission in hospital, including testing all hospital admissions, mask wearing and limiting hospital visitors. The work of the Nosocomial Transmission Group and the guidance they issued is considered in further detail in paragraph 316 onwards of M3/CNOW/01.

235. I also tried to bolster the requirement for adequate infection and prevention controls. When the Omicron variant arrived in Wales, I was particularly concerned about the impact on nosocomial infections. As part of the 21 Day Review in December 2021 I asked officials to place a focus on nosocomial transmission to help control the spread of Omicron in vulnerable closed settings, including reinforcing the basic procedures in place in hospitals (masks, distance and sanitizing) – an email sent from Reg Kilpatrick to officials in the Health and Social Services Group on 8 December 2021 and exhibited at **M3MEM01/098 – INQ000480022** refers to this.

236. In addition to the implementation of infection prevention and control measures, there was also in place the "*NHS Wales National Framework: The Management of Patient Safety Incidents following nosocomial transmission of Covid-19*" ("the Framework") which I exhibit at **M3MEM01/099 – INQ000116737.** This regulatory regime provided a further means of helping to reduce the impact of nosocomial infections across Wales. The Framework was developed and agreed by NHS organisations and the NHS Delivery Unit in March 2021, and the Welsh Government commissioned the NHS Delivery Unit to implement the Framework as a national function across Wales in June 2021.

237. In a Ministerial Advice dated 20 January 2022, which I exhibit at **M3MEM01/100 – INQ000116736**, I was advised that Local Health Boards had started to implement the Framework, and that the NHS Delivery Unit had been instrumental in overseeing the Framework at a national, strategic level by bringing together all NHS bodies through a series of Executive Strategy meetings to facilitate conversations and reach consensus decisions about implementation approaches where possible. However, notwithstanding that, I was advised that further investment was needed to accelerate progress. I agreed that additional funding of £4.54m per annum was given for a two-year period comprising of £4m to be provided to Local Health Boards and £540,000 to be given to the NHS Delivery Unit to support the implementation of the Framework at pace. I exhibit a copy of the Written Statement I made on 26 January 2022 announcing the investment at **M3MEM01/101 – INQ000480050**.

238. The Framework formed part of a wider NHS Wales National Nosocomial Covid-19 Programme to investigate and learn from cases of healthcare acquired Covid-19. This has been developed and led by the NHS Delivery Unit, who provided the Welsh Government with updates on the implementation of the Framework and lessons learned. On 29 March 2023 I made a Written Statement which I exhibit at **M3MEM01/102 - INQ000480068** in which I announced that the NHS Delivery Unit had published its interim national learning report, providing an overview of the programme and identifying some of the early learning themes emerging through the programme. As I mentioned in the Written Statement, I very much welcomed the report as I am committed to ensuring that learning from investigations will lead to meaningful change and improvements in the quality and safety of patient care. I understand the final report is due to be published shortly.

239. To the best of my recollection, I do not recall being made aware of a disproportionate impact of nosocomial infections on particular ethnicities or minority groups of healthcare workers, and particular roles of healthcare workers.

Personal Protective Equipment ("PPE")

240. As the Minister for Health and Social Services, I was ultimately responsible for the supply of key equipment and supplies in the procurement of the healthcare sector including PPE. However, at an operational level, responsibility for the

procurement of key health equipment and supplies prior to the pandemic and during the pandemic rested with the NHS Wales Shared Services Partnership. I understand that the procurement of PPE will be explored in further detail by the Inquiry in Module 5.

241. The difficulties in accessing PPE that were experienced at the start of the pandemic were resolved by the time that I was appointed in May 2021. For two weeks, I received weekly briefings on the stock holdings across all of the PPE held in Wales but this moved to monthly updates in June 2021. This was in view of the stable level of supply and use of PPE in Wales at that time. I exhibit an example of the briefing I received at **M3MEM01/103 – INQ000479976**. The briefings were helpful in that they enabled me to keep track of stock levels.

242. Whilst there were shortages of PPE during the early stages of the pandemic, I am not aware of any actual or impending shortages of PPE during my time as Minister for Health and Social Services. This is testament to the work undertaken by the Welsh Government and the NHS Wales Shared Services Partnership, including the Covid-19 Health Countermeasures Group (which ensured that pandemic stocks were deployed according to ministerial agreement) and the PPE Procurement and Supply Group (which was responsible for informing the PPE procurement decisions, including sourcing, distribution and policy implementation for health and social care in Wales).

243. On 23 December 2021, I received a letter from Dr David Bailey, Chair of the British Medical Association Cymru requesting FFP2 masks be made available for all frontline healthcare staff and FFP3 masks be made available for all staff working with known Covid-19 patients and in aerosol generating procedures. I exhibit a copy of this letter at **M3MEM01/104 – INQ000118727**. I am aware that Dr Bailey had sent a letter making similar requests to my predecessor, Vaughan Gething, in February 2021, which had followed a letter he had written to then-Prime Minister, Boris Johnson shortly before.

244. Having considered matters with my officials and having regard to the relevant UK Infection, Prevention and Control guidance, we were unable to agree to Dr Bailey's request, which was recorded in a comment in my notebook to which

the Inquiry has referred and which was exhibited earlier at **M3MEM01/039–INQ000327588** (at page 125). I sent a reply to Dr Bailey on 25 January 2022 confirming this, which I exhibit at **M3MEM01/105 – INQ000118729**.

245. In so doing, I confirmed that Wales, like all UK nations, was continuing to follow the UK Infection Prevention and Control guidance, which had been most recently updated on 17 January 2022, including as to their recommendations on PPE. This guidance, particularly insofar as it related to the expanded use of enhanced Respiratory Protective Equipment, had been reviewed by UK Senior Clinicians in mid-December 2021 who had concluded there was no more evidence to support a need for this than previously.

246. In accordance with UK Infection Prevention and Control guidance at that time, FFP3 masks were supplied to all NHS staff engaged in aerosol generating procedures and in other circumstances where a local risk assessment suggested a continuing risk of infection or transmission despite other measures being in place. I further set out that that guidance was implemented locally according to local risk assessments and plans, with those risk assessments to be documented and explained to staff. Finally, I confirmed that the Health and Safety Executive had recommended that FFP2 masks not be used in health and social care unless in an extreme contingency situation due to their lower filtration characteristics.

247. The Inquiry has asked me whether I consider that there were suitable and efficient channels of communication within the healthcare system for those using PPE to provide feedback about the quality and suitability of the PPE they were using, and any other concerns they had about PPE. At no point during my tenure as Minister for Health and Social Services was it drawn to my attention that there was an ongoing issue with PPE including with the quality and suitability of PPE, and, save for the above example involving the British Medical Association Cymru, at no point during my tenure was I informed or led to believe that there were other concerns about PPE. However, as is illustrated by the British Medical Association Cymru example above, where there were any such concerns, there were suitable and efficient channels of communication that permitted these to be considered and responded to by the Welsh Government's Health and Social Services Group.

248. Further, I am not aware of any inequalities related issues with PPE that were brought to my attention during the relevant period.

249. In July 2020, the Senedd Health, Social Care and Sport Committee recommended that the Welsh Government develop a strategy for securing a resilient supply of PPE, including a plan for stockpiling. The Welsh Government accepted the recommendation and in October 2020 NHS Wales Shared Services Partnership worked with the Welsh Government to produce the "*NWSSP Procurement Services PPE Winter Plan*". Key to the plan was the decision to buy and warehouse a physical stockpile of 24 weeks of key PPE items to improve resilience. The 24-week stockpile was comprised of physical stock to meet the estimated demand from business-as-usual PPE requirements (4 weeks), Covid-19 requirements (8 weeks), pandemic preparedness stock (4 weeks) and risks arising from the end of the EU Exit transition period (8 weeks).

250. When I was appointed Minister for Health and Social Services, the NHS Wales Shared Services Partnership had started to develop a longer-term strategy for PPE in Wales for the period 2021 to 2022. I exhibit Ministerial Advice which was provided to me on 29 June 2021 at **M3MEM01/106 – INQ000103977.** This advice recommended that until 1 July 2021 the stockpile should hold, as a minimum, 24 weeks supply, which included an 8-week contingency for residual risks related to EU Exit, but that beyond 1 July 2021 the stockpile should be tapered to hold, as a minimum, 16 weeks supply at 31 August. The 16 weeks included contingency for business-as-usual PPE requirements (4 weeks), Covid-19 requirements (8 weeks) and pandemic preparedness stock (4 weeks). Accordingly, the reduction in the PPE stockpile for the healthcare sector from 24 weeks to 16 weeks was to reflect the reduction in risk arising from the end of the EU Exit Transition Period as opposed to reducing the supplies relating to the pandemic.

Implementation of Infection Prevention and Control Measures

251. The Inquiry has asked me if I was aware of difficulties in implementing Infection Prevention and Control measures in the ageing Welsh NHS hospital estate. I am aware that the NHS data statement (reference M3/WGO/02) sets out

the concerns that were brought to the attention of the Welsh Government early in the pandemic regarding implementation of Infection Prevention and Control measures in the Welsh NHS hospital estate, most of which pre-dated my appointment as Minister for Health and Social Services.

252. However, I was aware that in March 2022, the Royal College of Nursing sent a briefing which I exhibit at **M3MEM01/107 – INQ000480074** setting out that the spread of Covid-19 was higher in areas of poor ventilation and called on the Welsh Government to invest in ventilation across the NHS estate. This generated Written Questions by Members of the Senedd requesting information about how the Welsh Government was evaluating actions taken by Local Health Boards to improve ventilation and CO2 monitoring within NHS estates across Wales. I exhibit a copy of my answer at **M3MEM01/108 - INQ000480080**, which referred to the work being undertaken by the NHS Wales Specialist Estates Services including: support to the Welsh Government in providing engineering scrutiny in business case/design submissions from the Local Health Boards including ventilation systems; providing support to Local Health Boards around ventilation related matters, including sitting on the Ventilation Safety Groups, appointing authorised persons to safely manage the ventilation systems and carrying out audits to confirm how well the ventilation systems were managed; carrying out full validations on critical ventilation systems when they were first installed; and being involved in a UK-wide NHS group looking at ventilation in healthcare settings, which considered the use of CO2 monitoring in healthcare.

Visiting Restrictions

253. The Inquiry has asked me for details of my involvement in the visiting guidelines or protocols issued, together with the reason for introducing restrictions and any issues or concerns brought to my attention regarding hospital visiting restrictions and my response to them.

254. At the time that I was appointed as Minister for Health and Social Services in May 2021 there was already in place visiting restrictions in hospitals, which had undergone a series of changes to balance the need for compassionate visits with robust infection prevention and control strategies to help control the spread of

coronavirus amongst patients, staff and the public. For information purposes I have set out below a table showing the key guidance that was in place prior to my appointment as Minister for Health and Social Services, but I did not have any role in the development or issuing of that guidance.

Key guidance on visiting restrictions issued prior to my tenure as Minister for Health and Social Services

Document Name	Exhibit Number	Document Date
Visitor guidance to in-patient health settings in times of Coronavirus (COVID-19)	**M3MEM01/109 –** INQ000399385	25 March 2020
Update to visitor guidance to in-patient health settings in times of Coronavirus (COVID-19)	**M3MEM01/110 – INQ000299228**	20 April 2020
Hospital visiting during the coronavirus outbreak: guidance – visiting with a purpose	**M3MEM01/111 – INQ000299514**	20 July 2020
Hospital visiting during the coronavirus outbreak: guidance	**M3MEM01/112 – INQ000469208**	30 November 2020
Hospital visiting during the coronavirus outbreak: Supplementary Statement November 2020	**M3MEM01/113 – INQ000469846**	30 November 2020
Review of hospital visiting	**M3MEM01/114 – INQ000469842**	1 April 2021

255. Following my appointment as Minister for Health and Social Services in May 2021, I became responsible for issuing any changes to the guidance on visiting restrictions following recommendations and considerations made by the

Hospital Visiting Guidance Working Group, which comprised of representatives from the NHS in Wales, Public Health Wales and the Welsh Government's Health and Social Services Group. I have set out below a further table showing the key changes to guidance that I was responsible for, and I have also set out below further information on the rationale for those changes.

Key guidance on visiting restrictions issued during my tenure as Minister for Health and Social Services

Document Name	Exhibit Number	Document Date
Hospital visiting during the coronavirus outbreak guidance	**M3MEM01/115 – INQ000082115**	18 June 2021
Hospital visiting during the pandemic: Supplementary statement June 2021	**M3MEM01/116 – INQ000082117**	18 June 2021
Hospital visiting during the pandemic: Supplementary statement December 2021	**M3MEM01/117 – INQ000469848**	14 December 2021
Hospital visiting during the coronavirus outbreak: guidance	**M3MEM01/118 – INQ000082810**	9 May 2022

256. At the time that I became Minister for Health and Social Services, the guidance on hospital visiting that was in place was the version issued on 30 November (exhibited earlier at **M3MEM01/112 – INQ000469208**) together with the Supplementary Statement also issued on 30 November (exhibited earlier at **M3MEM01/113 – INQ000469846**). In general terms, the guidance was designed to support local services when planning and implementing their rules on visiting and access arrangements in hospitals by providing a suggested "baseline" for hospital visiting during the pandemic for certain categories of inpatients (such as children, those with mental health conditions and those receiving long term care

etc) and providing guidance for accompanying patients to outpatient appointments. The Supplementary Statement allowed healthcare providers to depart from the baseline visiting position set out in the guidance in response to rising levels of Covid-19 transmission in their localities or falling levels of transmission in the local area. Fundamentally, implementation of the guidance was a matter of local determination based on local risk assessments and infection control measures.

257. On 18 June 2021, I was presented with a Ministerial Advice which I exhibit at **M3MEM01/119 – INQ000103976** seeking my agreement to include reference in the guidance on the use of lateral flow testing in relation to hospital visiting. I agreed the amendments to the guidance which were published on the same day (exhibited earlier at **M3MEM01/115 – INQ000082115**, and the supplementary statement at **M3MEM01/116 – INQ000082117**). I exhibit a copy of the Written Statement I made on 18 June 2021 at **M3MEM01/120 - INQ000271665**. As set out in the Written Statement, these amendments included a new annex developed by the Welsh Government Nosocomial Transmission Group which provided health providers with an 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. As set out in the Written Statement, the guidance reiterated 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. There was no expectation that the guidance would lead to health providers relaxing all visiting restrictions because the risk of nosocomial transmission remained high and therefore a cautious approach was maintained. However, there was an inherent recognition that a balance was required in terms of allowing visiting whilst also keeping people safe from the virus and that lateral flow testing could be a supportive tool in maintaining that balance.

258. The amendments made to the guidance on 18 June 2021 also removed the limit of one parent, guardian, or carer at the bedside at a time for paediatric inpatients and neonates, replacing it with guidance that allowed up to two to visit

subject to local determination, and subject to following a local risk assessment and maintaining social distancing. These changes were made following concerns raised in a report published by "Bliss" (a charity for babies born premature or sick) recommending that urgent action was taken to ensure that all relevant visiting guidance was updated to ensure that there was no blanket national policy preventing parents from caring for their baby together so that they could support on another – which was discussed at a meeting with the Deputy Minister for Health and Wellbeing on 8 June 2021. In making the decision to allow for two visitors for paediatric inpatients and neonates, I also took account of concerns raised by the Royal College of Paediatrics and Child Health and members of the public about the ability to maintain social distancing at all times which was reflected in the updated guidance.

259. On 30 June 2021, I attended a meeting held by the UK Department of Health and Social Care together with Health Ministers across the four nations to discuss the guidance on hospital visiting for young people with cancer, and whether there was a need for a four nations approach to hospital visiting for such patients. However, this never came to fruition. I exhibit an email chain following the meeting at **M3MEM01/121 – INQ000479986** which notes that our guidance already had a strong emphasis on local, evidence-based decisions that already provided sufficient flexibility to enable healthcare providers to allow young cancer patients to be accompanied to hospital appointments and receive visitors in hospital and that therefore no further changes were required. Furthermore, our guidance was not specific to any particular conditions to ensure fairness for those people suffering from a range of conditions.

260. As set out earlier in this statement, following Ministerial Advice dated 29 July 2021 exhibited at **M3MEM01/056 – INQ000103982**, I agreed to remove the requirement for fully vaccinated individuals who had been in close contact with a person who tested positive for Covid-19 to self-isolate. Notwithstanding that, I agreed not to relax existing visiting guidance for hospitals and care homes, regardless of vaccination status, in order to reduce the risks associated with contacts of confirmed, or potential, cases of Covid-19 when visiting vulnerable friends and family.

261. At a Cabinet meeting dated 23 August 2021, questions were raised over evidence that in some cases there were still significant constraints on visitors and people supporting those who were attending hospital for biopsy results. As set out in the minutes for that meeting, which I exhibit at **M3MEM01/122 – INQ000057893**, it was acknowledged that individual settings might have a need for tighter controls in place to comply with risk assessments or to respond to prevailing infection rates on site. The guidance on hospital visiting was subsequently shared between Ministers for information purposes, but it was not considered that any further changes were needed to the guidance at that time. I exhibit an email that was sent to me by the Deputy Chief Medical Officer on 27 August 2021 at **M3MEM01/123 – INQ000479999** noting the emphasis on local decision making in terms of hospital visiting restrictions and the ongoing need to control visiting in hospitals in order to keep vulnerable patients safe from the virus.

262. On 1 December 2021, I was presented with Ministerial Advice which I exhibit at **M3MEM01/124 – INQ000116711** seeking my approval to produce a Supplementary Statement to enable healthcare providers to restrict visiting to inpatients in hospitals and the accompanying of patients to scheduled and unscheduled appointments for the purposes of infection prevention and control in response to risks posed by infectious diseases, other than Covid-19. This was in view of the concerns raised over the prevalence of infectious diseases such as respiratory syncytial virus ("RSV") during the winter period, and other diseases such as influenza, norovirus and C-difficile, and to recognise that the decision-making process with regard to visiting in a health care setting during the pandemic may be multi-factorial. This was also at a time when rising rates of Omicron were being considered. I agreed the recommendation on 6 December 2021 and the supplementary statement was subsequently published on 14 December 2021 (exhibited previously at **M3MEM01/117 – INQ000469848)**.

263. On 28 April 2022, I was presented with Ministerial Advice which I exhibit at **M3MEM01/125 – INQ000116751** seeking my approval to substitute Annex 2 of the hospital visiting guidance with a new visiting guidance for maternity and neonatal services. The new visiting guidance for maternity and neonatal services outlined

that a nominated partner supporting a woman during hospital visits and parents/primary care givers were considered to be partners in care, including neonatal settings, and as such should not be considered as visitors but rather as essential visitors. Whilst the previous guidance had enabled healthcare providers to allow for a nominated partner and/or parent support to be present in maternity and neonatal services, concerns were raised during consultation with stakeholders, including service providers, regarding a lack of consistency amongst healthcare providers on the visiting restrictions in maternity and neonatal services. Although the new guidance retained the principle that the visiting restrictions in place were fundamentally a matter of local determination, it underscored the importance of partner support and parents as partners in care and included a number of key principles to enable a more consistent approach across Wales and thus providing equity of experience for maternity and neonatal services. I agreed the recommendations and the new guidance was published on 9 May 2022 (exhibited earlier at **M3MEM01/118 – INQ000082810**).

264. On 21 October 2022, I received Ministerial Advice which I exhibit at **M3MEM01/126 – INQ000480071** recommending that the hospital visiting guidance was paused in view of the Welsh Government's policy position as set out in "*Together for a safer future: Wales' long-term Covid-19 transition from pandemic to endemic*" exhibited previously at **M3MEM01/031 – INQ000066072** which was geared towards de-escalating Covid-19 measures such as hospital visiting restrictions with a view to living with coronavirus. At the time I felt that it was premature to remove the hospital visiting guidance in view of increasing rates of the virus. Thereafter, and as set out in an email exchange exhibited at **M3MEM01/127 - INQ000480057,** the guidance was subsequently removed on 11 November 2022 on the basis that it referred to legal restrictions and measures which were at that time obsolete. As set out in the email, there had been no concerns raised by the public regarding the removal of the guidance and, on reflection, I was content for it to be removed at that time particularly as Local Health Boards and NHS Trusts were continuing to implement their own hospital visiting policies to reflect local coronavirus rates.

265. The Inquiry has asked me to provide details of any concerns brought to my attention, or my assessment, regarding the impact of hospital visiting guidance from June 2021 onwards which allowed healthcare providers to depart from the guidance in response to local transmission rates. An inevitable consequence of allowing healthcare providers to implement their own rules on visiting restrictions as they see fit is that it can create inconsistencies in approach across Wales. This is illustrated in the examples I have provided above regarding variations in visiting rules across Wales for patients attending hospital for biopsy results, and for those attending maternity and neonatal services. In some circumstances, as was the case for the guidance on attending maternity and neonatal services, I felt it was important to strengthen the Welsh Government guidance to help create consistency across Wales, but I remained steadfast in my position that healthcare providers should retain the flexibility to tailor their approach on visiting restrictions in accordance with the position locally (e.g. local transmission rates, the ability to maintain adequate social distancing in the particular hospital etc). This was also consistent with the general approach adopted by the Welsh Government in relation to the healthcare system in Wales, and set out earlier in this statement, which enabled NHS bodies to remain responsible for operational decision making.

Part F: Shielding

266. The Inquiry has asked for details of my involvement as Minister for Health and Social Services in the decisions (i) to not advise the clinically extremely vulnerable to shield on 27 July 2021 and (ii) to close the shielding patient list from 31 March 2022. I took both of these decisions as Minister for Health and Social Services, and I have set out further detail on those decisions below.

Decision to not advise the clinically extremely vulnerable to shield on 27 July 2021

267. At the time that I was appointed Minister for Health and Social Services in May 2021, people that were clinically extremely vulnerable were not required to follow shielding measures. I exhibit a copy of a Written Statement issued by my predecessor, Vaughan Gething, at **M3MEM01/128 – INQ000337551** which sets out that, in view of the decreasing case prevalence, the Chief Medical Officer for

Wales recommended that the advice to the clinically extremely vulnerable to follow shielding measures was paused from 31 March 2021.

268. On 14 July 2021 I was presented with a Ministerial Advice note, which provided me with the latest advice from the Chief Medical Officer for Wales in relation to the clinically extremely vulnerable and I exhibit at **M3MEM01/129 – INQ000104028**. As set out in the Ministerial Advice note, the Chief Medical Officer for Wales maintained his position that there was no public health requirement to advise shielding measures at that time, because we were not seeing an associated increase in hospitalisations and deaths linked to prevalence of the virus in the community. Notwithstanding that, the Chief Medical Officer for Wales felt that, in view of further relaxations to the restrictions in accordance with the Welsh Government's Coronavirus Control Plan (e.g. allowing more people to meet indoors, and the reopening of organised indoor events), people on the shielding patient list may have concerns about their risk of exposure to the virus. For the purposes of providing reassurance, the Chief Medical Officer recommended that a letter should be issued in his name to those on the shielding patient list to advise on how to minimise their risk of exposure, and to provide an opportunity to get the vaccines where individuals had not yet taken up the offer whilst also promoting the booster and flu jab programmes.

269. I agreed the recommendations made by the Chief Medical Officer for Wales and issued a Written Statement on 27 July 2021 which I exhibit at **M3MEM01/130 – INQ000479993**. That Written Statement confirmed that, on the advice of the Chief Medical Officer, people on the shielding patient list were not required to shield but should take extra care to minimise their exposure. This was however with the exception of anyone who had received specific advice to shield by their own clinician. A copy of the letter issued by the Chief Medical Officer for Wales was attached to the Written Statement and is exhibited at **M3MEM01/131 – INQ000271726**.

<u>Decision to close the shielding patient list from 31 March 2022</u>

270. On 1 March 2022, I was presented with a Ministerial Advice exhibited at **M3MEM01/132 – INQ000103998** in which the Chief Medical Officer for Wales

recommended that we end the shielding programme and close the shielding patient list. By that time, shielding advice had been paused since 31 March 2021, but the Chief Medical Officer considered that he had no plans to re-introduce shielding advice on the basis that the existence of Covid-19 treatments, alongside specific aspects of the vaccination programme for the group who continued to be most vulnerable, provided sufficient reassurance that people in this category were offered appropriate protections.

271. I accepted the advice of the Chief Medical Officer for Wales that the shielding programme should be brought to an end on 31 March 2022, and I exhibit a copy of the Written Statement that I made to that effect on 10 March 2022 at **M3MEM01/133 - INQ000227382**.

Concerns re Decisions on 27 July 2021 and 31 March 2022

272. The Inquiry has asked whether there were any concerns brought to my attention, or my assessment, regarding the impact of the above decisions.

273. Throughout the relevant period as Minister for Health and Social Services, I remained highly aware of the need to balance the risks of harm posed by Covid-19 versus the risks of harm posed by non-Covid-19 harms. Whilst the fundamental ethos behind the shielding programme was to protect the most vulnerable in our society from the harms of Covid-19, I was very aware of the harms created by shielding measures which included isolation and loneliness. Accordingly, I felt that it was important that those shielding measures were only retained where they were absolutely necessary (i.e. where the benefits of shielding outweighed the harms). The advice provided to me by the Chief Medical Officer for Wales in the Ministerial Advice exhibited earlier at **M3MEM01/129 – INQ000104028,** which confirmed that there were no public health requirements to advise shielding measures in July 2021, was key to my decision not to reinstate the shielding measures for clinically extremely vulnerable persons.

274. In terms of the impact of my decision not to reinstate the shielding measures in July 2021, I was mindful that for some clinically extremely vulnerable people, my decision would have been welcomed as it meant that they were

relieved of the need to self-isolate but for others it may have brought concerns around their potential for exposure to the virus. For that reason, I was very hopeful that the letter sent from the Chief Medical Officer for Wales to those on the shielding patient list would provide a degree of reassurance on impact of the decision on them, and how they could keep themselves safe (such as keeping contacts to a minimum, and meeting others outside). I was also aware that my decision not to reinstate the shielding measures would mean that those people would not be eligible for Statutory Sick Pay, but I felt that it was not a reason in and of itself to reinstate shielding measures.

275. I am not aware of any specific concerns that came to my attention following my decision not to advise clinically extremely vulnerable people to shield on 27 July 2021. However, I do recall receiving concerns from members of the public following the emergence of the Omicron variant in December 2021. By way of example, I exhibit a letter at **M3MEM01/134 - INQ000480028** I received on 13 December 2021 from Rebecca Evans MS citing a request from one of her constituents to reinstate shielding in view of the threat of an Omicron surge. In Ministerial Advice dated 17 December 2021 and exhibited at **M3MEM01/135 – INQ000136876**, I received advice from the Chief Medical Officer for Wales indicating that he maintained his position that there was no public health requirement to reinstate shielding measures in view of the Omicron variant. This was on the basis of the balance of harms, the efficacy of vaccines and booster programmes, and the availability of new medications. I agreed the advice of the Chief Medical Officer and also agreed to the issuing of a letter to those on the shielding patient list advising them how to minimise their risk of exposure to the virus, and to provide an opportunity to highlight the importance of having booster vaccines and to promote the importance of lateral flow testing before meeting others.

276. I exhibit a copy of my response dated 21 December 2021 to the concerns raised by the member of public at **M3MEM01/136 – INQ000480031** and the Written Statement that I made on 23 December 2023 at **M3MEM01/137 - INQ000227352** indicating that the Chief Medical Officer would be writing to everyone on the shielding patient list to provide them with updated advice about the Omicron

variant. I exhibit a sample copy of the Chief Medical Officer for Wales' letter at **M3MEM01/138 - INQ000353303**.

277. I remained very cautious in my decision to end the shielding programme. On 9 September 2021, I was provided with Ministerial Advice, previously exhibited at **M3MEM01/003 – INQ000353269** indicating that the UK Government had decided to close its shielding programme and return to the situation pre-Covid-19 where people managed their own conditions with their health professionals. Whilst the Chief Medical Officer for Wales recommended that shielding advice should no longer form part of the Covid-19 response in Wales, I did not feel that it was the appropriate time to end the shielding programme, given that the number of cases of Covid-19 was continuing to rise. However, by March 2022, I felt that the timing was right in view of our deeper understanding of the virus, efficacy of the vaccination programme amongst the clinically extremely vulnerable, the availability of medical treatment, and the fact that we had not reinstated shielding advice since March 2021. I do recall receiving concerns from some members of the public regarding my decision, but I felt confident that it was the right decision. I exhibit a copy of the letter sent by one of my officials dated 6 April 2022 in response to concerns raised by a member of the public at **M3MEM01/139 - INQ000480093.**

Part G: Other Matters

Long Covid

278. The Welsh Government recognised early in the spring of 2020 that there would be a need for rehabilitation services for people who had been significantly affected by Covid-19 infection. I have set out below information relating to the Welsh Government's approach to long Covid, together with details of my involvement in the decisions made relating to long Covid.

279. On 22 October 2020, my predecessor, Vaughan Gething, issued a Written Statement which I exhibit at **M3MEM01/140 - INQ000412528** outlining the policy position adopted by the Welsh Government with respect to long Covid. As set out in the Written Statement, the Welsh Government's approach to people suffering from long Covid was focused on providing care and support as close to home as possible

through community rehabilitation services and, only where necessary, from inpatient rehabilitation services. This was not a decision that I had any involvement with as it pre-dated my appointment as Minister for Health and Social Services.

280. As set out earlier in this statement, the Welsh Government does not have any role in the direct commissioning of health services, but instead provides strategic oversight in relation to the delivery of the healthcare system in Wales. Accordingly, it was for the Local Health Boards to deliver services at the local level for the management of long Covid in accordance with the policy position adopted by the Welsh Government.

281. In order to inform and underpin the development of local services for the management of long Covid, and to ensure consistency in the approach adopted across Wales, the Welsh Government collaborated with Local Health Board Directors of Therapies and Health Sciences, Assistant Medical Directors and other key stakeholders in the NHS to develop the "*All Wales Community Pathway for Long Covid*". I exhibit a copy of the Pathway at **M3MEM01/141 - INQ000412547**, which sets out actions which should be taken by a healthcare professional when presented with a patient who may be suffering with long Covid, using existing primary care services as the access point for patients and providing information on directing patients to the right service for their individual needs. This includes self-help, advice, multi-professional assessment, investigations, treatment or rehabilitation support. The Pathway was designed to complement the NICE clinical guideline on the management of long Covid and was also drafted in accordance with the principles of "*A Healthier Wales*" (which was exhibited earlier in this statement) of avoiding harm, promoting and supporting self-management and value-based care accessed in the community and tailored to the individual's specific needs. The '*All Wales Community Pathway for Long Covid*' was issued to the NHS in Wales by Dr Andrew Goodall on 22 February 2021 as set out in the letter exhibited at **M3MEM01/142 - INQ000469096.** I did not have any involvement in its development as it pre-dated my appointment as Minister for Health and Social Services.

282. The Institute of Clinical Science and Technology was subsequently commissioned to produce a digital 'guideline" incorporating the All-Wales Community Pathway for Long Covid, together with a suite of online resources and training providing the latest information for managing long Covid. This was commissioned to enable easy access

to the All-Wales Community Pathway for Long Covid, and also to ensure consistency in its application amongst health practitioners in primary and community care settings. Although the digital guideline was launched after my appointment as Minister for Health and Social Services (further information on the launch is provided below), the decision to fund and commission the digital platform was taken by my predecessor Vaughan Gething pursuant to a Ministerial Advice dated 15 March 2021 and exhibited at **M3MEM01/143 – INQ000235884.**

283. Accordingly, by the time that I was appointed Minister for Health and Social Services in May 2021 there were established systems and processes already in place across the NHS in Wales in the management of long Covid. However, I remained committed to supporting people who were suffering with long Covid. I was very proactive in asking for more support for those suffering with long Covid as one of my first initiatives after being appointed as Minister for Health and Social Services. I visited patients who were suffering with long Covid at two different multi-disciplinary clinics.

284. Within a month, I was provided with Ministerial Advice dated 10 June 2021 which I exhibited previously at **M3MEM01/004 – INQ000145131**, I was advised that funding of £5m was required in order to support the expansion and development of primary and community services to meet the needs of those recovering from the effects of Covid-19, either directly as a result of infection (long Covid) or indirectly as part of the broader effects of the pandemic. As set out in the Ministerial Advice, this funding was to be given under the label of Adferiad (Recovery) programme to:

a. Fund allied health professionals, GPs and primary and community staff, rehabilitation support workers and the development of primary and community infrastructure to flexibly deliver services to help people recover from Covid-19, long Covid and those more widely impacted by the pandemic, e.g. mental health, wellbeing and isolation.
b. Provide high quality, evidence-based training, Continued Professional Development and digital resources for all health professionals to assist in diagnosing, investigating and treating long Covid and supporting people in their treatment and rehabilitation.

c. Invest in digital tools which would provide data about service demand and capacity modelling and to ensure the NHS helps people make the right treatment decisions for their care and treatment.
d. Support the development/planning for community diagnostic hubs in primary care.

285. I exhibit a copy of the Oral Statement I made on 15 June 2021 announcing the £5m investment in support of the Adferiad (Recovery) programme at **M3MEM01/144 – INQ000338737**, together with a copy of the policy document for the Adferiad (Recovery) programme at **M3MEM01/145 - INQ000412566** which set out further information about long Covid and the support available through the programme. The fundamental policy underpinning the Adferiad (Recovery) programme remained focused on providing assessment, diagnostic, treatment and rehabilitation support through existing primary and community care structures, with referral to more specialised services for those who required it. The additional funding enabled such support to be further developed and expanded to meet patient needs. A key part of the Adferiad (Recovery) programme was the launch of the aforementioned digital guideline incorporating the All-Wales Community Pathway for Long Covid previously commissioned by Vaughan Gething. This was instrumental in helping to achieve our policy aim of ensuring that all healthcare practitioners across Wales had access to the very latest information on diagnosing, managing and treating people with long Covid so that patients received the appropriate support and care.

286. We planned to review the Adferiad (Recovery) programme every six months to monitor and assess the efficacy of the services provided, in line with any new emerging evidence for long Covid treatment and management, and Local Health Boards were given until 14 January 2022 to submit reports against the Adferiad (Recovery) programme. I exhibit Ministerial Advice dated 2 February 2022 at **M3MEM01/146 – INQ000116740** which was accompanied by a summary of the reports submitted by Local Health Boards which I exhibit at **M3MEM01/147 – INQ000480089.** The key findings of the reports were:

a. All Local Health Boards in Wales were providing integrated, multidisciplinary rehabilitation services for people with long Covid and all

were accessible via primary care and delivered as close to home as possible.

b. All of these services had referral pathways to specialist secondary care assessment and treatment for those patients who clinically needed it, and the data showed that only a small percentage (approximately 3.5%) of people with long Covid required referral to secondary care services.
c. The number of people recorded as having long Covid strongly correlated to the number of people referred to Local Health Board long Covid services, indicating people who were going through primary care were reaching long Covid services.
d. The national patient evaluation showed people participating in long Covid services were reporting an improvement in their health outcomes.
e. The national patient evaluation also showed people participating in long Covid services reporting satisfaction with the quality of the experience of those services.
f. The NHS Wales Covid Recovery App and Long Covid Digital Guideline were effective digital tools in supporting patients to self-manage their conditions and providing healthcare professionals with up-to-date advice and learning to aid diagnosis and treatment of long Covid.

287. The report concluded that:

a. The current service model for people with long Covid in Wales was effective in meeting the needs of the majority of people with long Covid.
b. The service model would benefit from further development (e.g. expanding capacity in community rehabilitation, recruitment of additional staff, continuing to learn about the best approaches to enable people to recover).
c. There was value in integrating these services with those for people with other long-term conditions who also benefitted from a community based rehabilitative service close to home.

288. I exhibit an Oral Statement I made on 8 February 2022 at **M3MEM01/148 – INQ000480060** which summarises the findings and conclusions of the review, and commits to continuing to monitor, learn and improve services.

289. In view of the positive findings from the review, I invested a further £5m of non-recurrent funding to the NHS in Wales to support the ongoing provision of services under the Adferiad (Recovery) programme. The funding was also helpful to ensure the continued availability of the All-Wales Community Pathway for Long Covid and the NHS Wales Covid Recovery app, both of which have been effective digital tools in supporting patients to self-manage their conditions and providing healthcare professions with up-to-date advice and learning to aid diagnosis and treatment of long Covid. I exhibit a copy of the Ministerial Advice dated 15 March 2022 at **M3MEM01/149 – INQ000116782** seeking my agreement for the funding which I duly provided.

290. Beyond the relevant period, I have continued to invest in the Adferiad (Recovery) programme and in March 2023 I increased the funding to £8.3m on a recurrent basis. This increase in funding enabled services to be expanded to provide support for people with other long-term conditions which have similar rehabilitation and recovery needs to those with long Covid, such as Myalgic Encephalomyelitis and Chronic Fatigue Syndrome. I exhibit a Written Statement I issued on 14 March 2023 providing an update on the Adferiad (Recovery) Programme and the increase in funding at **M3MEM01/150 - INQ000412567**.

DNACPR Notices

291. The Inquiry has asked me to provide details of any concerns brought to my attention regarding the use of Do Not Attempt Cardio-Pulmonary Resuscitation ("DNACPR") notices during the relevant period and the steps I took in response to such concerns.

292. During business questions in the Senedd on 1 February 2022, Mike Hedges MS informed me that he had been told by the Covid-19 Bereaved relatives group that Do Not Attempt Cardiopulmonary Resuscitation had been used without discussion with relatives. In my written response, which I exhibit at **M3MEM01/151 - INQ000480088**, I explained that Wales has its own clinical policy for Do Not Attempt Cardiopulmonary Resuscitation for adults which was updated in November 2020 (prior to my appointment as Minister for Health and Social Services) and aimed to offer conversations to those close to individuals at the end of life so that the wishes of the

person concerned were implemented as far as practically possible, and makes it clear that consultation must take place with those concerned. I also referred to:

a. Two letters issued by the Chief Medical Officer for Wales and Chief Nursing Officer for Wales to all Local Health Boards which set out that age, disability or long-term condition should never be a sole reason for issuing a DNACPR order against an individual's wishes, and emphasised that decisions should be made on an individual and consultative basis with people. I exhibit a copy of those letters dated 17 April 2020 and 10 March 2021 respectively at **M3MEM01/152 - INQ000300106** and **M3MEM01/153 - INQ000227370**. These were both issued prior to my appointment as Minister for Health and Social Services.
b. A joint statement issued (prior to my appointment) by the Care Inspectorate Wales and Healthcare Inspectorate Wales in April 2020 emphasised the importance of personalised, compassionate communication as being central to the Do Not Attempt Cardiopulmonary Resuscitation process. A copy of the joint statement is exhibited at **M3M01/154 - INQ000227432**.
c. Details on how to contact Care Inspectorate Wales and Healthcare Inspectorate Wales in respect of the concerns raised.

293. I also received a written question from Russell George MS asking if I was aware of any breach of DNACPR orders during the pandemic. I exhibit a copy of my written response dated 14 April 2022 at **M3MEM01/155 - INQ000480092** in which I noted that there had been some high-profile media reports of blanket Do Not Attempt Cardiopulmonary Resucitation being applied and that I had also been notified of isolated incidents where it had been alleged that the policy had not been followed.

294. The isolated incident to which I was referring related to a report made to the Learning Disability Ministerial Advisory Group of an instance of a decision to issue a DNACPR notice for an individual on the basis of a learning disability. As set out in the letter, the Welsh Government takes these allegations very seriously and, in each case, has acted promptly to investigate and seek confirmation of the governance and assurance processes in place within the relevant Local Health Board to ensure these decisions were taken in line with extant clinical guidance. This involved a further letter

being sent to the Local Health Boards in Wales by the Chief Medical Officer and Chief Nursing Officer for Wales which I exhibit at **M3MEM01/156 – INQ000412593** and also reiterated that Do Not Attempt Cardiopulmonary Resuscitation decisions should not be made purely on the basis of an individual's age, having an impairment, learning disability, autism, mental illness or other condition. I am not aware that the Local Health Boards raised any significant concerns.

Non-Covid-19 Related Healthcare

295. As outlined in paragraph 133 above, during the relevant period for which I was Minister for Health and Social Services, I would receive 'NHS Covid updates' by e-mail and, in detailing hospital bed occupancy (both critical care and otherwise), these updates would confirm how such occupancy was divided between Covid-19 and non-Covid-19 patients. This allowed me to see the changes in those levels on a regular basis.

296. Further, the 'latest figures' update e-mails I received would include a 'Non-Covid NHS Pressure' section which expressly outlined an update on matters including A&E performances, ambulance response rates and, where relevant, any specific matters of concern arising in identified hospitals or Local Health Board areas. I have already referred above to one such example involving the concerning increase in drug overdose-related admissions to Morriston Hospital in early-July 2021. Whilst such updates were largely high-level, they provided me with a general overview as to how the Local Health Board areas were coping with non-Covid-19 healthcare demands.

297. In addition, and as detailed earlier in this statement, the Data Monitor produced by Knowledge and Analytical Services included consideration of health and social care themes. This summarised measures of Covid-19 and non-Covid-19 related hospital activity and was later expanded to include a separate Suspected Cancer Pathway Dashboard, which included data on matters such as cancer referrals. This Dashboard was updated monthly from January 2021 onwards, and I began to receive the same as an annex to a specific Suspected Cancer Pathway briefing each month.

298. The Dashboard provided a high-level summary of key measures on the Pathway including data on wait times from suspicion to first appointment, first diagnostic test

and being informed as to whether they have cancer or not. The accompanying briefing provided analysis on matters including the number and source of cancer referrals, with comparative data for the preceding year, along with information on diagnostics, performance and treatment. Analysis was presented generally and, thereafter, on a Health Board-specific basis.

299. I exhibit an example of one such briefing received on 15 July 2021 in respect of May 2021 and the accompanying Dashboard at **M3MEM01/157 – INQ000480053** and **M3MEM01/158 – INQ000480076** respectively.

300. The Covid update group which met weekly (referenced at paragraph 37 above) also drew my attention to any significant issues.

301. In addition to this, the Covid-19 delivery workstream dashboard produced for Cabinet (and updated regularly in advance of Cabinet meetings) provided high-level updates as to the Welsh Government's health response, which included non-Covid-19 healthcare matters focused upon maintaining NHS services relating to areas such as mental health and cancer, and primary care generally. I exhibit an example of one such dashboard at **M3MEM01/159 – INQ000479953**.

302. There would also have been other work ongoing to monitor non-Covid-19 related healthcare levels within the Welsh Government by officials within the Health and Social Services Group of which I would not have been involved in and / or necessarily directly aware of.

303. Insofar as steps taken to ensure non-Covid-19 related healthcare remained available, much of this work was carried out during the early stages of the pandemic and prior to my appointment as Minister for Health and Social Services. For example, Andrew Goodall details at paragraph 565 onwards of his statement M3/WGO/01 the work undertaken by Welsh Government officials with the All Wales Cancer Network to consider the likely impact of the pandemic on cancer care and to support cancer service delivery during this period. I am also aware that my predecessor, Vaughan Gething, has addressed such matters in his statement.

304. Shortly after my appointment as Minister for Health and Social Services, and in July 2021, I was made aware of the conclusions of a report undertaken by the Academy of Medical Sciences (on the instruction of the UK Government Chief Scientific Adviser) which sought to consider the health and social care challenges that the forthcoming winter 2021/22 period was likely to present. This report expressly identified the wider health impacts (including upon non-Covid-19 related healthcare) of the pandemic as a key challenge for the forthcoming winter period. A copy of the e-mail sent to me at that time is exhibited at **M3MEM01/160 - INQ000479985**.

305. Insofar as communication of the continued availability of non-Covid-19 related healthcare is concerned, the steps taken by the Welsh Government (in conjunction with relevant partner agencies) to ensure the effectiveness of messaging and engagement with the public about the importance of seeking care promptly throughout the pandemic were summarised in an Evidence Paper prepared for the purpose of the Health and Social Care Committee in relation to their investigation into the impact of the waiting times backlog on people in Wales. I exhibit a copy of this paper at **M3MEM01/161 - INQ000480056**, which sets out details of various campaigns used including the development of "staying healthy / keeping well" information links developed for Health Boards to use to signpost patients and the development of a series of patient-facing videos by the planned care programme in collaboration with the Help Us Help You campaign. Health Boards also developed a number of local strategies to support and improve patient communication, with Hywel Dda developing a one-point contact for all patients waiting enquiries, which had initially been piloted for orthopaedics.

306. In addition to the general approach above, there were several further ways in which such communication occurred. In my role as Minister for Health and Social Services, I would regularly undertake press conferences. Whilst the content of these would vary depending on the ongoing issues at the time, these would include reference to non-Covid-19 healthcare issues where appropriate. I exhibit one such example of a press conference where funding and waiting times in relation to non-Covid-19 healthcare was discussed at **M3MEM01/162 - INQ000480038**.

307. Where appropriate, I would also publish Written Statements to increase awareness of certain non-Covid-19 healthcare concerns, including the services available, what work was being undertaken by the Welsh Government and other related bodies and pertinent health information such as relevant symptoms. An example of one such Written Statement relating to an expected increase in Respiratory Syncytial Virus in children published on 30 July 2021 is exhibited at **M3MEM01/163 - INQ000480087**.

308. As at the end of the relevant period in May 2022, the Wales Cancer Network was working through a proposal to take to the Wales Cancer Alliance and the Cancer Awareness Campaign Group to develop a campaign that would both raise awareness of cancer symptoms and encourage people to access health services if they had any concerns or symptoms. I previously exhibited at **M3MEM01/017 - INQ000066520** a response I prepared that details such work being undertaken in response to a recommendation from the Health and Social Care Committee to do so.

Suspension of Routine Inspections by Health Inspectorate Wales

309. The decision to suspend all routine inspections of healthcare settings by the Healthcare Inspectorate Wales was taken on 17 March 2020. This was prior to my appointment as Minister for Health and Social Services and so I would not have been privy to the details of such decisions such that I could have formed any concerns regarding this decision. At the time of my appointment, Health Inspectorate Wales had already recommenced some of its routine onsite assurance work from 26 April 2021 and was continuing to increase the same with a view to returning to the full inspection programme by 1 July 2021.

310. I am aware that my predecessor, Vaughan Gething, has dealt with this initial suspension in his Module 3 statement to the Inquiry from paragraph 338 onwards. As he confirms, there is a deliberate separation between the Healthcare Inspectorate Wales and the Welsh Government's Health and Social Services Group in recognition of the former's professional independence and judgement.

311. I am aware that there was a further (much shorter) suspension of routine inspections by the Healthcare Inspectorate Wales in response to Omicron, which ran from 15 December 2021 to 1 February 2022. Whilst I did not have any involvement in this decision, I also do not recall having any particular concerns surrounding it at the time. It seemed to be a perfectly sensible decision in the circumstances as they were presenting. We did not know how serious the Omicron variant would become and whether our vaccines would give us the protection we needed. I was also aware that Healthcare Inspectorate Wales had continued to discharge its assurance and inspection role during the earlier, much longer suspension at the outset of the pandemic.

312. Upon it becoming clear that Omicron was not developing in accordance with the worst-case scenarios modelled and that our vaccines continued to provide protection, routine inspection activity was resumed by Healthcare Inspectorate Wales.

Part H: Lessons Learned

313. I am aware that Judith Paget has prepared a 'Lessons Learned' statement (M3/WGO/03) on behalf of the Welsh Government that sets out the health-related lessons learned reports and external reviews that were commissioned by or on behalf of the Welsh Government in relation to the pandemic response. I respectfully refer the Inquiry thereto for the full detail of such matters.

314. Insofar as my own experiences, I outlined my views upon these in my Module 2B statement to the Inquiry. As the Cabinet Secretary for Health and Social Care in Wales, it is important to state clearly that we are still fighting Covid-19. We remain mindful of the need to be prepared for the next potential health emergency, but are still dealing with the peaks and troughs of Covid-19. We continue to provide booster vaccinations multi-annually for vulnerable people and are coping with the significant after-effects of the pandemic for the NHS and social services.

315. In order to respond to the pandemic effectively, particularly in the early stages of the pandemic, planned care had to be temporarily suspended. This inevitably resulted in a backlog, the effects of which are still being felt. Significant NHS and social care staff absence because of the virus is still impacting on our ability to deliver services, and members of the public are still being admitted for treatment to our hospitals with Covid-19. Our waiting lists are longer now with thousands of people still counting the cost of Covid-19 on their physical and mental health and the number of people dentists can see is more limited as a result of needing to implement infection control measures, reducing access for the public.

316. One way of assisting with the ongoing situation could be to separate planned care from urgent care. However, in Wales in particular, such separation can be somewhat more difficult where hospitals are geographically far apart and the ability to transfer between hospitals is consequently more restricted.

317. As a Welsh Minister (now Cabinet Secretary), I need to balance the need to support patients today, to put in place measures to decrease the inequalities of tomorrow and to understand that demographic shifts mean that more of our resources in future will be required by our elderly population.

318. At the same time, we need to be horizon scanning as we understand that a lack of preparation for a future pandemic will be expensive, not just financially but for individuals and for society. Thanks to policies of austerity, high inflation and in a world where we now live with Covid-19, and its consequences, preparing for a future pandemic requires us to make some carefully balanced considerations. We need to decide how much resource we can protect just in case we need it for a future virus battle. Our ability to apply the learning from Covid-19 may be constrained by our challenging financial circumstances.

319. However, we should not lose sight of the positive things that we learnt and have carried with us in the years since the height of the pandemic. In the NHS, huge changes were introduced incredibly quickly. For years we had been talking about the digital transformation of the NHS – but overnight GPs, consultants and crucially the public accepted that remote consultations could be as effective as

those face to face. These are now mainstream and accepted methods of administrating clinical services.

320. This has resulted in many novel services now being remotely available, such as remote dermatology consultations. It also permits those living in rural areas to have access to consultants on a remote basis instead of having to travel long journeys for appointments where a face-to-face is unnecessary.

321. Another matter that I consider worked exceptionally well in the pandemic was the ability of the NHS in Wales to respond to a crisis. Clinicians were able to deliver and respond quickly and efficiently, which was particularly assisted by the availability of additional resources provided by pandemic funding.

322. One of the key lessons learned during the pandemic was a need to empower those on the front line of the health service to make swift decisions in such situations. At the outset of the pandemic, there was sufficient funding available to address this, which meant that decisions could be made quickly with sufficient professional freedom for those engaged directly in the provision of healthcare.

323. In the broadest sense, and with the benefit of hindsight, we are now aware that the pandemic disproportionately affected those who came from poorer backgrounds and those households who already had challenging health issues. We are aware that if we want to avoid the kind of inequality of impact of a virus in future, that measures need to put in place in advance to reduce inequalities in society. We must also be sensitive and realise that any intervention during a crisis needs to consider the needs of the most vulnerable, those who are socio-economically disadvantaged, disabled people and Black, Asian and Minority Ethnic people, in particular.

324. Accordingly, and in seeking to address this for any future pandemic scenario, we need to address the issue of health equity. In order to do this, a Government-wide approach would almost certainly be required, as this is an issue that extends far beyond the scope of the NHS to fix solely.

325. As Cabinet Secretary for Health and Social Care, the significant challenge for me now is to manage the pressures on health and social care services, in difficult financial circumstances, whilst also identifying the necessary planning and funding to prepare for the next major health emergency. To the extent to which I am able, I am attempting address some of the existing health inequity through the targeting of underlying health conditions that we know exacerbated the impacts of Covid-19 but which can be treated, such as tackling obesity.

326. Further, and in considering any recommendations, I think we should be projecting what the healthcare system will look like in future. This will involve more support being provided to patients in the communities rather than in hospitals, which would mean that any future pandemic situation would look considerably different to that experienced in the relevant period.

Statement of Truth

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

Signed:

Personal Data

Dated: 15 July 2024