Witness Name: Vaughan Gething
Statement No.: M3 1
Exhibits: 198
Dated: 15 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF VAUGHAN GETHING

I, Vaughan Gething M.S, will say as follows: -

Introduction

1. First and foremost, I would like to express my sincere sympathies to those who were affected by and lost loved ones because of the Covid-19 pandemic, just as I have in my previous statements in previous modules. The pandemic touched the lives of everyone: my own, my colleagues, our communities, our workforces across Wales, but none more so than the many families who lost loved ones. I will continue to recognise at every opportunity the loss, pain and sadness far too many are still experiencing.

2. The pandemic undoubtedly placed further needs and demands for health and social care services in Wales. I cannot emphasise enough how quickly things changed both inside the Welsh Government and outside in these sectors and I would like to offer my appreciation and to recognise the exceptional efforts and commitment of health and social care workers who went over and above in fulfilling their duty to protect the people of Wales.

3. My response to the Inquiry's request for evidence made under rule 9 of the Inquiry Rules 2006, referenced M3-VGE-01, will cover the period from 1 March 2020 to 13 May 2021, this period covers my tenure as Health and Social Care Minister (which I will refer to in this statement as "the pandemic period").

Personal Background

4. Since 6 May 2011, I have represented Cardiff South and Penarth as a member in the Senedd. Before that, I worked as a solicitor specialising in employment law in Cardiff and was a partner in the Thompsons LLP firm. I am a member of four unions (GMB, UNISON, Community and Unite Unions).

5. I first entered the Welsh Government on 26 June 2013 when I was appointed the Deputy Minister for Tackling Poverty. In September 2014, I was appointed Deputy Minister for Health, a position which I held until May 2016 when I became the Cabinet Secretary for Health, Well-being and Sport. In 2018, the name of that portfolio was changed to the Minister for Health and Social Services, but for the purposes of this Inquiry, there was no relevant change in my responsibilities. For ease of reference, I shall use the latter term to describe the post in which I served between 2016 and 2021. I held that office until 13 May 2021 when I was appointed Minister for the Economy.

6. On 20 March 2024 I was appointed as the First Minister for Wales.

Ministerial role

7. The Minister for Health and Social Services ("MHSS") holds a broad range of responsibilities. Although this is not an exhaustive list, my responsibilities at the outset of the pandemic and relevant to Module 3 included;
    a) public health;
    b) NHS delivery and performance;
    c) escalation procedures;
    d) receipt of, response to, and direction of reports from Healthcare Inspectorate Wales;
    e) oversight of the Welsh Government's relationship with Audit Wales regarding activities relating to the NHS;
    f) subject to certain exceptions, medical workforce training and development; research and development in health and social care;
    g) mental health services;
    h) patient experience and involvement;

8. A full list of the Minister for Health and Social Services' ministerial responsibilities is exhibited in **M3VGE01/001 - INQ000321251** and **M3VGE01/002 - INQ000187304**.

9. Ministers have responsibility for, and are accountable to, the Senedd for the exercise of all the powers in their portfolio. Supported by officials, they set the policy and strategic framework within which the NHS in Wales should operate, determine the strategic distribution of overall NHS resources, set the standards and performance framework for the NHS in Wales and hold NHS leaders to account. Supporting the Minister for Health and Social Services is the Deputy Minister for Health and Social Services. Within the date range relevant to this Module, the role of Deputy Minister for Health and Social Services was held by Julie Morgan, MS.

10. The Minister for Health and Social Services works closely with the Chief Executive of NHS Wales, the Chief Medical Officer (Wales) and the Chief Nursing Officer (Wales). I understand that colleagues in these roles are all assisting the inquiry with evidence and will endeavour to not repeat evidence where possible.

11. The Minister for Health and Social Services receives policy advice from the Welsh Government's Health and Social Services Group which is led by a senior civil servant who holds the dual role of Director General Health and Social Services and Chief Executive of NHS Wales (explained in more detail below).

12. In the May 2021 Cabinet re-shuffle, I was appointed Minister for the Economy (ministerial responsibilities for the Minister for the Economy are exhibited in **M3VGE01/003 - INQ000321252).** My colleague Eluned Morgan MS was appointed as Minister with responsibility for the Health and Social Services portfolio. I understand that Eluned Morgan MS has also provided evidence to the Inquiry in her role as Minister for Health and Social Services and as such this statement will only cover my tenure up until May 2021.

13. During the pandemic, as the Minister for Health and Social Services I was responsible for the following issues which are relevant to Module 3:

a) Preparedness for the NHS and Health sector, NHS initial capacity and ability to increase capacity and resilience;
b) The management of the pandemic in all health care settings, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' ("DNACPR") decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels;
c) Shielding and the protection of the clinically vulnerable;
d) International travel restrictions;
e) The procurement and distribution of key equipment and supplies, including personal protective equipment ("PPE") and ventilators;
f) The National Testing Programme;
g) The National Vaccination Programme;
h) The consequences of the pandemic on provision for non-Covid-19-related conditions and needs;
i) Oversight of the health data and evidence.

14. In October 2020, the ministerial responsibilities were amended to add Covid-19 response, screening and vaccination and health innovation and digital. This change recognised and formalised that throughout 2020 a great deal of my time was spent focusing on the Covid-19 pandemic, of which the healthcare system was just one aspect. I gave evidence in Module 2B about my role in the Welsh Government's broader response to the pandemic, including non-pharmaceutical interventions, border controls, vaccine development and test and trace.

15. In October 2020, the new role of Minister for Mental Health, Wellbeing and the Welsh Language was created and was first held by Eluned Morgan MS. She was given responsibility for mental health services. This had the dual effect of raising the profile of mental health and wellbeing, which we knew would be affected by the pandemic, and alleviating the pressure on me to allow me to focus on the pandemic response in Wales. I believe that this decision was effective and I appreciated the support I received from Eluned Morgan MS at this time.

My working pattern

16. I am asked to describe my daily working pattern as Minister for Health and Social Services. The Ministerial role is busy and varied. My working day depends upon the priorities and commitments that I face at any given time. For example, the period immediately after Christmas and January is extremely busy as winter pressures increase the demand for NHS services across the UK. Pre-pandemic, my day would typically include back-to-back meetings and visits throughout the day. Generally, I would work at weekends and for at least three hours in the evenings five days a week. Like many others the pandemic was and remains the busiest, most unprecedented time of my political career. In addition to extended hours in the office I worked in the evenings and often past midnight. I believe I worked every evening and weekend from March 2020 until April 2021 save for a short family break in August and Christmas day.

17. The Health Minister's time is very much taken up with Senedd business, attending a large number of debates and statements. Until social distancing measures were introduced in March 2020 I would have been based at the Ministerial offices in Ty Hywel, Cardiff Bay, unless on Ministerial engagement and/ or events. Following the introduction of social distancing, myself, the First Minister and other members of the Cabinet worked on a hybrid basis from Cathays Park, the Welsh Government's principal offices in Cardiff or from home.

18. During the initial period of the pandemic my working pattern and similarly that of my Cabinet colleagues and many Welsh Government officials would have been 7 days a week, working from early in the morning to late at night, including a regular number of weekend meetings. In addition to my role as Minister for Health and Social Services I also maintained my duties to my local constituency.

19. From the second week of March 2020 routine meetings and appointments were postponed or rescheduled, this was to allow my full attention to be given to the immediate response to the pandemic. Meetings that remained in the calendar were Covid-19 related, either internally to the Welsh Government or externally. This remained the pattern going into April and May.

20. Cabinet usually meet once a week, on Mondays, whilst the Senedd is sitting. In March 2020, some Cabinet members would attend Cabinet meetings in person and some would attend via a video link. By 20 April 2020, only the First Minister and I were present in person, with everyone else via video link.

21. From 11 March 2020 the First Minister added an additional meeting, on Wednesdays, of the Covid-19 Core Group to enable frequent contact between those ministers with the most direct involvement in the Welsh Government's response to Covid-19. Initially this comprised the First Minister, me, the Minister for Housing and Local Government, Julie James MS and the Minister for Education, Kirsty Williams MS. This was the core membership, but there was an open invitation to other ministers to attend. On 25 March 2020, the Covid-19 Core Group membership was widened to include the Leader of the Welsh Local Government Association and from 1 April 2020 the opposition party leaders of Plaid Cymru and the Welsh Conservatives. The Chief Executive of the Wales Council for Voluntary Action was invited from 8 April 2020 and various external groups (such as the Police, Army and the Black Asian Minority Ethnic Covid-19 Advisory Group) were invited to provide updates from their respective areas as well. It became an information sharing forum and the format was for regular updates from the Chief Medical Officer (Wales)' office, the Director General of Health and Social Services Group/Chief Executive of the NHS and the Welsh Local Government Association.

22. It was not unusual for my diary to be booked with several meetings per day, with very few breaks. The majority of meetings were conducted in person or via Microsoft Teams. Very few external meetings/appointments were agreed during the initial period. Those that were conducted in person were of importance to our response, for example on the 20 April 2020 I visited Ysbyty Calon y Ddraig, Field Hospital, for a launch and tour of the facilities.

23. It was not unusual for me to meet with or speak to the First Minister, the Chief Medical Officer and the Director General of the Health and Social Services Group/ Chief Executive Officer (CEO) of NHS Wales multiple times a week.

24. I also participated in several media interviews throughout March and April 2020, this included UK wide outlets such as Sky news, Channel 4, ITV and Channel 5 news and the BBC.

Ministerial responsibility for the NHS in Wales

25. Dr Andrew Goodall, who was the Director General of Health and Social Services and Chief Executive NHS Wales while I was Minister for Health and Social Services and is the current Permanent Secretary for the Welsh Government, has explained the legislative background to the NHS in Wales, which will not be repeated in full here (see paragraphs 16- 20 of M3-WGO-01).

26. As Minister for Health and Social Services, my legal duties in relation to the healthcare system were derived from the National Health Service (Wales) Act 2006 ("the 2006 Act"). Section 1 of the 2006 Act provides that the Welsh Ministers are responsible for the promotion and provision of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales, and in the prevention, diagnosis and treatment of illness. The 2006 Act also requires that the Welsh Ministers provide certain services, such as hospital accommodation and health services or facilities.

27. The Welsh Ministers discharge their statutory duty to provide health services by delegating to a network of NHS bodies such as Local Health Boards, NHS Trusts and Special Health Authorities. Local Health Boards act as both providers and commissioners of healthcare services in their areas. They are responsible for the health of their local populations.

28. As distinct legal entities from the Welsh Ministers, each NHS body is responsible for ensuring appropriate governance arrangements are in place to maintain effective operation and delivery of health services to the people of Wales. This involves making decisions in relation to matters such as how and where services are delivered, and by whom and entering into contracts with healthcare providers. The Boards of NHS bodies also provide internal governance; their key roles being to formulate strategy, ensure accountability (by holding the organisation to account for the delivery of the

strategy) and to shape the culture of the organisation. Ultimately, NHS bodies in Wales have operational decision-making with a focus on day-to-day activities and resource allocation to ensure efficient service delivery. NHS bodies are expected to deal with immediate concerns, such as managing patient flow, staffing, and logistics within hospital settings.

29. The Minister for Health and Social Services (through the Health and Social Services Group) is responsible for strategic decision-making involving long-term planning, policy development, and achieving broader goals all for promotion and provision of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Wales. Accordingly, decision making undertaken by the Minister for Health and Social Services is generally taken at the strategic level as opposed to the operational level – the latter being the responsibility of the NHS bodies themselves in the delivery of health services. However, Ministerial decisions may be required to facilitate operational decisions by Local Health Boards by providing funding or support or impact how those decisions are taken by issuing statutory directions or non-statutory guidance.

30. The link between the NHS and Welsh Ministers is perhaps best outlined by reference to the NHS Planning Framework. The Welsh Ministers are required by the NHS (Wales) Act 2006 approve and fund NHS bodies' Integrated Medium Term Plans ("IMTPs") setting out how the NHS body will deliver services to meet the needs of their local population over a three-year accounting period. These plans are linked to the NHS Planning Framework which gives statutory guidance on developing plans which responds to Ministerial and governmental priorities. The Welsh Ministers report to the Senedd before the end of any three-year accounting period on the Local Health Board's and Trust's performance[1].

31. This planning process is one of the key enablers to achieving high-performing, timely, safe and sustainable services. The Minister for Health and Social Services is able to exercise a degree of influence over the way in which NHS bodies plan, secure and deliver health services. This typically involves issuing strategic policy which provides

[1] Under section 175(1) of the 2006 Act.

the context within which NHS bodies must plan and deliver health services. A key example of such policy is a "Healthier Wales" which is exhibited at **M3VGE01/004 - INQ000066130** and contains the Welsh Government's long-term vision on how the NHS should be delivered and what it should seek to achieve.

32. The Minister for Health and Social Services also has the power to issue directions to NHS bodies on the exercise of its functions, which may be given by regulations or an instrument in writing and must be complied with.

33. I am specifically asked about the extent to which the Welsh Government had a responsibility to ensure consistency across the NHS in Wales in its response to the Covid-19 pandemic and whether there were any formal structures or mechanisms in place to do so.

34. All Health Boards are required to plan against the priorities set by the Welsh Government, which sets a baseline consistency throughout Wales. Health Boards are expressly empowered and required to develop their plans to meet the needs of their own local populations. Integrated Medium Term Plans from all Health Boards are seen and assessed by the Welsh Government which thereby has a national overview of Health Board planning.

35. Whilst Integrated Medium Term Plans need to be owned locally by individual organisations, there must be sufficient consistency in presentation and content to allow the Welsh Government to have a clear picture across Wales.

36. Integrated Medium Term Plans should respond to requirements agreed collectively for Wales through the national programmes. The national programmes have been developed to support local action to deliver sustainable, accessible, cost-effective and efficient services at or as close to home as possible. Working across the patient pathway, organisations must maintain a clear focus on efficiency, consistency, collaboration and quality. The programmes are developing whole system approaches, to encourage a proactive, prudent and value-based health and social care environment. Integrated Medium Term Plans must demonstrate a full commitment to standardising approaches, methodologies and services. Integrated Medium Term

Plans should evidence commitment and compliance with the national programmes and provide assurance on what actions are being taken. Areas of non-compliance must be highlighted including the remedial actions adopted.

37. Guidance to support policy requirements or to provide information about good practice may also be issued to NHS bodies by the Welsh Government, as it was during the pandemic. Whether NHS bodies are legally required to comply with such guidance or information will depend upon whether it is issued by way of direction or not, but in the case of the latter there is an expectation that NHS bodies will follow Welsh Government guidance unless there is good reason not to, such as differing local arrangements or requirements. Where there is no guidance on a particular issue, NHS bodies have the discretion to develop their own and there is no requirement for this to be signed off by the Welsh Government.

38. Variation across Health Boards and Trusts was one stream of the work of the Covid-19 Planning and Response Cell's Essential Services Group (see paragraph 187 of M3-WGO-01), in particular the need to facilitate a national, consistent approach where needed, including guidance to support clinical prioritisation, mitigation of risks, addressing interdependencies. This would be achieved through the Clinical Reference Group who would provide advice and source clinical engagement and leadership opportunities.

39. The Welsh Government is responsible for the funding of the healthcare system in Wales and making decisions about how resources are distributed, which is another means of shaping the delivery of the healthcare system in accordance with key ministerial priorities.

40. In the event that an NHS board is not performing one or more of its functions adequately or at all, or where there are significant failings in the way that the body is being run, the 2006 Act enables the Welsh Ministers to issue intervention orders as a means of making improvements in the management of the NHS body. However, these are powers of last resort. Whilst intervention orders were issued during the pandemic, they did not relate to the Health Boards' response to the Covid-19 pandemic.

Oversight and decision making during the pandemic

The Health and Social Services Group

41. The Minister for Health and Social Services is supported by the Health and Social Services Group within the Welsh Government. The Group is led by the Director General of the Health and Social Services Group ("HSSG") who also holds the role of Chief Executive NHS Wales, a role which NHS bodies are accountable to. The Chief Executive NHS Wales/ Director General Health and Social Servies Group is responsible for exercising the strategic leadership and management of the NHS in Wales and responsible for the robust stewardship of NHS funds. Therefore, decisions about healthcare services were made and implemented by NHS bodies and overseen by the Chief Executive of NHS Wales/Director General Health and Social Services Group.

42. The Chief Executive of NHS Wales/Director General Health and Social Services Group is the most significant senior civil servant with whom I had regular contact throughout the pandemic. As stated above, this post was held by Dr Andrew Goodall whilst I was Minister for Health and Social Services. The combined role of Chief Executive NHS Wales/ Director General Health and Social Services group is a significant and distinctive post. It brings together the responsibilities of a Director General in the Welsh Government with the leadership and oversight of the NHS in Wales.

43. On 21 February 2020, the Health and Social Services Group Covid-19 Planning & Response Group ("HSSPRG") was established by the Director General of the Health and Social Services Group / Chief Executive NHS Wales and the Chief Medical Officer within the Welsh Government. The Group brought together strategic representatives of the Welsh Government's Health and Social Services Group, NHS bodies in Wales and social care. I was not directly involved in the work of the Health and Social Services Group Covid-19 Planning & Response Group which was convened and coordinated by Dr Andrew Goodall. In terms of the timing for the establishment of this group and details of the seven subgroups that were established (see M3-WGO-01 paragraphs 78-83). I understand the information from the themed sub-groups and

main group was reported to the Director General of the Health and Social Services Group / Chief Executive NHS Wales and the Chief Medical Officer who I met with frequently. Strategic decisions by myself and the Welsh Government would be informed by the information coming from the Planning & Response Group and its subgroups and implementation taken forward by the Health Boards.

44. In addition to the above, the wider Health and Social Services Group and its officials would also provide me with information and support in making decisions. This would be via the Ministerial Advice process by which officials in the Health and Social Services Group would provide advice and recommendations. Included in the Health and Social Services Group were key advisors including, but not limited to, the Chief Medical Officer, Chief Nursing Officer and Chief Scientific Adviser for Health. I have set out further information on these roles below as they are of particular interest to Module 3.

NHS Wales Planning Framework

45. During the Covid-19 pandemic it was recognised that the usual planning process for 3-year Integrated Medium Term Plans, as described above, was not suitable (see paragraphs 200-203 of M3-WGO-01). In order to allow the NHS bodies in Wales to more quickly and efficiently plan and respond to the developing circumstances, the Welsh Government asked Health Boards to submit weekly plans from March 2020 to May 2020.

46. On 24 April 2020 the then First Minister published 'Leading Wales out of the Coronavirus pandemic: a framework for recovery' which is exhibited at **M3VGE01/005 - INQ000349353**. The weekly plans submitted by the NHS in Wales were aligned with the ministerial priorities set out in this framework which required the potential for the Covid-19 related 'harms' to the people of Wales listed below to be considered when making decisions:

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

b) indirect harm caused to individuals if services including the NHS became overwhelmed due to any sudden large spike in demand from patients with Covid-19 on hospitals, critical care facilities and other key services;
c) harms from non-Covid-19 illness, for example if individuals did not seek medical attention for their illness early and their condition worsened, or more broadly from the necessary changes in NHS service delivery made during the pandemic in Wales to pause non-essential activity;
d) socioeconomic and other societal harms such as the economic impact on certain socioeconomic groups of not being able to work, impacts on businesses of being closed or facing falling customer demand, psychological harms to the public of social distancing and many others; and
e) (The fifth harm added by the Technical Advisory Group in July 2021, as outlined in the paper exhibited as **M3VGE01/006 - INQ000239550**) harms arising from the way Covid-19 has exacerbated existing, or introduced new, inequalities in our society.

47. In May 2020 the operational planning cycle moved to quarterly. I exercised my power to issue directions to NHS bodies through the following Quarterly Operational Planning Frameworks. In doing so, there was a greater level of control in ensuring a consistent approach to the Covid-19 pandemic and the developing picture. The Operational Planning Frameworks took into account the modelling and data that was produced by the Technical Advisory Cell and the Technical Advisory Group and NHS Wales bodies were required to create their own plans for delivery in their local areas based upon that information. The Operating Frameworks were accompanied by technical guidance issued by Dr Goodall to the NHS bodies to inform the development of NHS plans. This was one way that the Welsh Government could influence and control the Health Boards' responses to the Covid-19 pandemic and the consistency between Health Boards:

a) NHS Wales Operating Framework - quarter 1, exhibit **M3VGE01/007 - INQ000182468** refers;
b) NHS Wales Operating Framework - quarter 2, exhibit **M3VGE01/008 - INQ000336745** refers;

c) NHS Wales Operating Framework – quarter 3 and 4, exhibit **M3VGE01/009 - INQ000182474** refers; and

d) Welsh Government Winter Protection Plan 2020-21, exhibit **M3VGE01/010 - INQ000300011** refers.

48. I issued a Written Statement to announce the Quarter 2 Operating Framework, noting that we had moved out of a period of critical planning and response and into a longer period where the health and care system had to remain prepared for any future peaks and effectively provide essential services and other high quality care and treatment. Plans in Quarter 2 were asked to focus on new ways of working and managing Covid-19. In particular:

a) **Routine" services** – The framework recognised that delivery of routine services was a matter for local decision making based on an assessment of whether this could be done safely. However, one area that would require additional focus was that of Children's Services.

b) **Primary care** - During May further guidance was issued to support continued recovery of primary care services across all contractor professions. In Quarter 2 I expected to see a particular focus on both the development of plans to support clusters in the safety netting of those at risk and people who were symptomatic or tested positive to Covid-19 and implementation of the care homes Direct Enhanced Services (DES).

c) **Social Care Interface** - The framework continued to signal the need to provide extended support to care homes to reflect the additional needs of residents with Covid-19 symptoms, and the additional operational consequences on staff, supplies and occupancy levels.

49. In December 2020 the Planning Framework 2021-22 exhibited in **M3VGE/011 - INQ000353194** was issued requiring organisations to develop an annual plan for 2021-22. The 2021-22 Framework built on the quarterly frameworks issued in 2020-21 and drew on the priorities set out in the Welsh Government's Winter Protection Plan. The 3-year Integrated Medium Term Plan Planning framework was reintroduced for the 2022-2025 period and the statutory process recommenced.

50. The relative size of both the Welsh Government and the NHS in Wales, together with the structures in place and the role of the Health and Social Services Group in particular meant that the Welsh Government was well equipped to make this rapid change to its governance process in order to adapt to the novel challenges placed.

The role of Cabinet and Ministerial colleagues

51. Cabinet is the central decision-making body of the Welsh Government. It is the collective forum for Welsh Ministers to decide significant issues and to inform colleagues about important matters. Cabinet reconciles ministers' individual responsibilities with their collective responsibility.

52. Under normal circumstances, Cabinet meets once weekly while the Senedd is sitting. Its business consists, in the main, of matters which significantly engage the collective responsibility of the Welsh Government, either because they raise significant issues of policy or because they are of critical importance to the public. The final decision as to whether an item should be discussed at Cabinet is made by the First Minister.

53. Decisions relating to the healthcare system in Wales are not routinely made at Cabinet but would be made by me as the Minister for Health and Social Services as part of the Ministerial Advice process (see below).

54. There were, however, times when I would introduce a paper and request that Cabinet agree the broad policy ambitions. These would typically be papers which outlined long term strategic health policy for Wales and would not relate to specific healthcare decisions.

55. An example would be '*A Healthier Wales'* which, as the long-term plan for health and social care, was presented to Cabinet for agreement before publication in 2018. Occasionally, Cabinet would be updated on the progress of the plans previously agreed. For example on 21 September 2020 I presented a Cabinet Paper *'A Healthier Wales Two Years On'* which I exhibit at **M3VGE01/012 - INQ000368331** to provide a progress update. That paper noted:

a) The Welsh Government had worked closely with partners in local authorities, Health Boards and the third and independent sectors, and through the first Supplementary Budget for 2020-21 provided an additional £573 million to the Health & Social Services Main Expenditure Group (MEG) to support the Covid-19 response. This included £492 million to help Health Boards and Trusts meet the initial costs of responding to the pandemic with funding for personal protective equipment, field hospitals, additional staffing, testing and additional medical equipment and consumables. An £800m stabilisation package for the Welsh NHS was announced in August 2020 to support the development and implementation of a Winter Protection Plan to prepare for a potential Covid-19 second wave alongside usual winter pressures, whilst continuing to increase access to essential services. This latest package took the total of Welsh Government Covid-19 support to the Health and Social Services Main Expenditure Group to more than £1.3 billion.

b) During the pandemic local services made rapid advances in implementing key aspects of the Primary Care Model for Wales.

    i. We saw increased cluster level collaboration and service models being adapted to support the separation of Covid-19 and non-Covid-19 patient flows.

    ii. The rapid implementation of telephone triage had taken place across Wales with a 'phone first' culture becoming quickly embedded.

    iii. Through accelerated investment during the Covid-19 response we put in place the infrastructure and systems required to enable video consultations with clinicians and provided devices to facilitate this. Feedback on these new ways of working was very positive, highlighting the time and travel expenses saved when compared to traditional models of accessing treatment. Going forward that would

mean that patients would be able to access care in the most efficient and appropriate way.

iv. Working with Digital Communities Wales to ensure the vulnerable and digitally excluded were also able to access services.

v. Accelerated decision making and investment along with industry enabled the implementation of digital advances at pace. The Welsh Government maintained its focus on infrastructure and retained these new ways of working. Work was underway to establish a new Special Health Authority (SHA); Digital Health and Care Wales by April 2021.

c) We anticipated an increasing demand for rehabilitation from people affected by the pandemic. This included people recovering from Covid-19, people whose planned care was paused, people who delayed seeking help and people impacted by lockdown. Health Boards were working with partners to assess population need and develop rehabilitation services to meet that need. The Welsh Government provided £10m to Regional Partnership Boards in support of the surge response to fund new and enhanced home care packages to enable patients to leave hospital for their ongoing assessment and recovery.

d) The wellbeing of our workforce was of paramount importance in helping us to provide high quality care. During the pandemic our health and care staff went over and above what could ever be expected of them and, in some cases, experienced hugely traumatic events. We worked with employers, Health Education and Improvement Wales, Social Care Wales and Trade Unions to provide a range of resources and practical support for all staff. A wellbeing focused sub-group of the Wales Partnership Forum was also established to respond at pace to the needs of our workforce.

e) During the pandemic over 130,000 people were shielded within their communities – an unprecedented action to provide care via food boxes,

medicines, and social contact and wellbeing support. Instrumental to this activity was the partnership with local authorities and County Voluntary Councils. In March 2020 we provided an initial fund of £24 million to support Wales' voluntary sector in response to Covid-19 and established the Voluntary Services Recovery Fund.

f) Covid-19 compounded existing health inequalities in Wales. In the short term our A Healthier Wales focus would be on reducing inequalities in Covid-19 outcomes, including direct and indirect harms. Longer term we would prioritise action in response to the wider socio-economic impact of the pandemic, as well as reducing risk factors across the population with a focus on deprived areas.

56. Whilst I was largely the principal decision maker in relation to matters concerning the healthcare system in Wales, the First Minister on occasion was asked to provide agreement alongside myself or to note the advice provided by officials to me in order to make the decision. Other Ministers (such as the Minister for Finance) or the Counsel General might have also been asked to agree or to note the advice from officials set out in the Ministerial Advice.

57. I would meet regularly with the First Minister to provide assurance on the delivery of my portfolio of responsibilities. During the pandemic this was a more intense engagement particularly focused on non-pharmaceutical interventions and international travel. The headroom within the NHS and how the NHS was coping in this most challenging of circumstances was a key consideration in relation to decisions on non-pharmaceutical interventions being taken by the Welsh Government.

58. Where decisions impacting the healthcare services in Wales during the Covid-19 pandemic did require discussion with or contribution from my Ministerial colleagues I generally felt that we were working together effectively. Whilst proposals may have been discussed or debated if necessary I do not recall any instances where I felt constrained in fulfilling my duty to the NHS in Wales by the First Minister or other Ministers or where the Welsh Government response was unduly hindered. Ultimately

our collective commitment was to save lives and protect the NHS and we were united in that regard.

Ministerial Advice

59. Where I was required to make decisions about policy, operations, legislation or other significant issue, Ministerial Advice would be submitted. The Ministerial Advice process is the formal method through which Welsh Government officials, provide advice (see paragraphs 51- 54 of M3-WGO-01).

60. I exhibit a table at **M3VGE01/013 - INQ000321255** which lists the relevant Ministerial Advice submitted to me either for a decision or to note during the relevant period, together with the decision taken. Hundreds of Ministerial Advice (over 400) were submitted in relation to the health and social services portfolio. Over 300 of the Ministerial Advice submissions were sent to me as lead Minister.

61. The Welsh Government's Ministerial Advice process ensured that I was properly equipped to make robust and defensible decisions. Ministerial Advice submitted to me provided with me the information, advice and options I required to make those decisions. I saw some Ministerial Advice in draft, first to comment on or give a steer for. Some formal Ministerial Advice came after a discussion with officials. When a final Ministerial Advice was provided I would still need to read, reject or question the advice – as I did.

Funding the NHS in Wales

62. The Welsh Ministers remained responsible for funding the NHS in Wales throughout the pandemic and had the power under the NHS (Wales) Act 2006 to provide additional funding to NHS bodies where required. Dr Goodall has described the process through which NHS bodies requested and accessed this funding (see M3-WGO-01 paragraphs 204- 217).

63. Dr Goodall has confirmed that in the financial year 2020-21, the Welsh Government issued additional Covid-19 funding allocations to the NHS in Wales, from budgets

within the Health and Social Services Group (see paragraphs 214- 217 M3-WGO-01). These totalled £1.170 billion for revenue expenditure and £133 million for capital purposes. This funding went to Local Health Boards, Trusts and Special Health Authorities in Wales.

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

a) Increased staffing levels
b) Critical care capacity and field hospitals
c) The use of private hospitals
d) Primary care including GP surgeries e.g. video and online consultations.
e) Provision of healthcare and treatments for patients with Covid-19
f) Research & development during the pandemic.
g) Convalescent plasma therapy
h) Support for hospices and palliative care.
i) Discharge of patients from hospital and support in social care
j) Support for doctors, nurses and other healthcare staff for helping to deal with the impact of the pandemic.
k) Infection control and preventing the spread of Covid-19 within health and care settings.
l) Support and communication on shielding and the impact on the clinically vulnerable. Diagnosis and treatment of post-Covid-19 conditions including long Covid.
m) Bereavement support.
n) Capital investment in equipment and premises that supported the delivery of the measures above.
o) Extension of the existing Influenza vaccination programme (for greater coverage)
p) Introduction of the Covid-19 vaccination programme.

65. In March 2020 the First Minister established the 'Star Chamber' to oversee and co-ordinate the Welsh Government's fiscal response to the pandemic, supported by the Minister for Finance. Where additional funds requested by NHS bodies were to be met by Welsh Government funds managed by the Star Chamber the Ministerial Advice would be scrutinised by the Star Chamber.

66. For example, on 5 June 2020 I attended the Star Chamber, together with Dr Goodall, Alan Brace and Jane Runeckles to discuss and explain the expenditure on the Covid-19 response to date. The minutes for this Star Chamber are exhibited at **M3VGE01/014 - INQ000338573**.

Key Working Relationships

Chief Medical Officer

67. The Chief Medical Officer for Wales (CMO(W)) is as a member of staff of the Welsh Government designated by the Welsh Ministers. Sir Frank Atherton was appointed to this role in 2016 and remains on a part time basis in the role. I understand Sir Frank Atherton is also assisting the Inquiry with evidence and as such has explained the role of Chief Medical Officer (Wales) in detail in his statement (paragraphs 4-18).

68. Despite being a civil servant and adhering to the Civil Service code of conduct, the Chief Medical Officer (Wales) retains a high degree of independence and separation from the Government and is free to provide advice without regard to government policy or direction. Before Covid-19 I met regularly with the Chief Medical Officer (Wales) about a wide range of issues. He would provide me with an overview of the Welsh population's health; highlighting areas of concern that needed to be considered by the Government in Wales

69. The Chief Medical Officer (Wales)'s advice to me and other Welsh Ministers became much more frequent during the pandemic. From around mid-April to October 2020 I had a weekly, usually Monday morning, check-in meeting with the First Minister and the Chief Medical Officer (Wales) which was attended by key officials and Dr Robert Orford, the Chief Scientific Adviser for Health. The Chief Medical Officer and Dr Robert

Orford would provide updates to set the tone for the priority areas for officials that week or leading up to the 21 day review period. Discussions of the wider healthcare response would be high level, focusing on NHS capacity, but would not descend to operational detail.

70. The Chief Medical Officer (Wales) would attend Covid-19 Core Group meetings and Cabinet meetings on a three weekly basis to inform the discussion on the review of the restrictions imposed by Health Protection (Coronavirus) (Wales) Regulations 2020. He also represented the Welsh Government in the Joint Biosecurity Centre (JBC) meetings.

71. The Chief Medical Officer (Wales) attended the senior clinicians group in order to listen to and understand the challenges that they faced. Where necessary, he would either in writing or verbally update me on issues and concerns arising within that group to ensure I was properly sighted on the challenges faced by those working within the healthcare system.

The Chief Scientific Adviser for Health (Wales)

72. The Chief Scientific Adviser for Health (Wales) is the professional lead for healthcare scientists in NHS Wales. The Chief Scientific Adviser for Health gives technical and scientific specialist advice on health science and protection. Dr Rob Orford was the Chief Scientific Adviser for Health during the pandemic, and he led the Welsh Government's scientific and technical response, as well as establishing and co-chairing the Technical Advisory Group.

73. The Technical Advisory Group and the Technical Advisory Cell provided data and advice which informed the decisions that I was required to make. As noted above I regularly met with the Chief Scientific Adviser for Health along with the Chief Medical Officer.

Chief Nursing Officer for Wales

74. During the relevant period three different individuals held the position of Chief Nursing Officer in Wales ("CNO").
    a) Jean White: 29/10/2010 – 06/04/2021
    b) Gareth Howells (Interim Chief Nursing Officer): 07/04/2021-30/08/2021
    c) Sumeshni ("Sue") Tranka: 30/08/2021-present

75. The role of Chief Nursing Officer for Wales and Nurse Director, NHS Wales entails setting the professional agenda and future direction for the nursing and midwifery professions in Wales and acting as a senior adviser to the Welsh Ministers on all matters relating to nursing and midwifery practice and education. This includes providing leadership, advice, guidance, and support for delivery of the Welsh Ministers' priorities for nursing and midwifery in Wales.

76. The Chief Nursing Officer for Wales is responsible for the professional performance and development of the executive nurse directors in the seven Local Health Boards, three NHS Trusts, and the Welsh Health Specialist Services Committee ("the Nurse Directors"). This is a significant professional role in the Welsh Government's oversight of the NHS in Wales' delivery and performance, and the Chief Nursing Officer (Wales) participates in performance review meetings with NHS Wales organisations led by the Director General, Health and Social Services. The Chief Nursing Officer (Wales) is assisted by a team of Nursing Officers.

77. The Chief Nursing Officer would directly advise me and the Deputy Minister for Social Services on matters related to the portfolio of responsibility described above. I understand a full list of advice submitted to me by the nursing directorate has been listed (see paragraph 101 of M3-CNOW-01). The Chief Nursing Officer for Wales would also attend meetings that I was invited to, for example, quarterly meetings with the Directors of the Royal College of Nursing and Royal College of Midwifery and would contribute views and opinions in papers before they would be issued to me for approval, for example see **M3VGE01/015 - INQ000366593**.

<u>Special Advisers</u>

78. Within the Welsh Government my Special Adviser also assisted me in responding to the Covid-19 pandemic by providing information gained in meetings held with internal and external stakeholders across health and social care. She would meet with representatives from the public sector, scientific, professional advisers, policy leads and lawyers in order to highlight any cross-cutting issues or to provide updates on key areas.

79. Special Advisers are appointed by the First Minister to help ministers on matters where the work of the Government and the work of the Government Party overlap and where it would be inappropriate for permanent civil servants to become involved. Special Advisers are employed as civil servants, but they are subject to a separate Code of Conduct.

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

Chief Executive Officers of the Local Health Boards

81. The seven Local Health Boards, three NHS Trusts and two Special Health Authorities are directly accountable to the Minister for Health and Social Services through the Chief Executive of NHS Wales/Director General. Concerns and issues were generally raised by the Chief Executive Officers of Local Health Boards through Dr Andrew Goodall however there were occasions that concerns were raised with me directly (see below).

82. The NHS Wales Executive Board was an established meeting before the pandemic which took place monthly with a formal agenda. This continued through the pandemic to provide executive leadership, direction and oversight of the performance, delivery, quality and safety of NHS services, workforce and functions in Wales. I did not usually attend these meetings but would receive relevant feedback and briefings.

83. Dr Goodall held twice weekly meetings with Chief Executives and weekly meetings with Chairs and Chief Executives which were regularly attended by me and/or the Deputy Minister. I have exhibited, as an example, the minutes for the meeting dated 15 April 2020 which my diary shows that I attended- **M3VGE01/016- INQ000369537**. At that meeting the discussions included providing updates about the latest SAGE advice and the non-pharmaceutical interventions being considered by the Welsh Government. PPE was raised and it was agreed that it was necessary to ensure that there was a level of confidence in how PPE was being deployed. Concerns were to be treated seriously, with an agreed way of sharing regular information with staff. An update was provided on the latest testing figures and the availability of medicines, as well as noting the non-covid-19 activities were significantly reduced with A&E attendances down by 60% and GP attendances down by 25%.

84. Those Chief Executives were, in turn, in communication with frontline healthcare workers and had the opportunity to express the concerns of frontline staff to inform the action being considered and taken by the Welsh Government. These meetings facilitated regular touch points and enabled co-ordination and mobilisation of actions, the identification and mitigation of risks and regular and ongoing engagement and support. Between 15 April and 13 May 2020, I was meeting weekly with NHS Chairs and Chief Executives to hear directly from them about the situation and challenges that they faced, and to answer any questions that they might have had.

85. During the pandemic, I was closer to and more aware of operational decisions that were being made by NHS bodies in Wales than I ordinarily would have been because the outcomes of those decisions and an understanding of the operational challenges faced by the NHS in Wales were relevant to the strategic decisions that I was asked to make or contribute to as part of the Welsh Government's broader response to the Covid-19 pandemic. For example, the allocation of hospital capacity and the availability of PPE were not matters on which I would ordinarily have been aware of the detail but it was expressly considered during Cabinet reviews of the restrictions. I exhibit the Cabinet minutes at **M3VGE01/017 - INQ000221014.**

86. Ordinarily, I would visit hospitals regularly and meet with front line and Health Board staff. This was not possible during the pandemic and so I relied upon Dr Goodall and

my regular meetings with Trade Unions to ensure the voices and concerns of healthcare staff were readily available.

87. I felt that this structure allowed me to have sufficient knowledge and understanding of the circumstances and challenges facing the NHS in Wales to inform the broader strategic decisions I was required to make and contribute to for the Welsh Government's response to the Covid-19 pandemic as a whole. I recall my counterpart Matt Hancock MP expressing frustration that on occasion he was unable to reach into NHS England. The Welsh structure, and Dr Goodall's role in particular, meant that I did not share the same dislocation.

The Welsh NHS Trusts and Special Health Authorities

88. As above for Local Health Boards, Dr Goodall would also meet with the Welsh NHS Trusts and Special Health Authorities and act as the primary link between myself and these NHS bodies. 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 Service Trust as there was extreme pressure on the flow through Emergency Departments.

Trade Unions

89. Representatives from the Trade Unions within Wales were members of the Shadow Social Partnership Council. The remit and membership of the Shadow Social Partnership Council was expanded in the pandemic to provide a voice and the participation of social partners. The Council was provided with the latest scientific advice and with an update from the First Minister and Chief Medical Officer (Wales). I attended these meetings frequently throughout the relevant period.

90. I also met with regularly with Trades Union colleagues throughout the pandemic, and I would speak to Trade Union leaders and representatives in advance of significant decisions or actions being taken, in accordance with the Welsh Government's partnership approach to engaging with staff and their representatives.

91. Trade Unions did, on occasion, contact me with specific issues or concerns that they had on behalf of their members. I exhibit **M3VGE01/018** **INQ000501530** and **M3VGE01/019** **INQ000501537** by way of example, correspondence received from Unison Cymru in June 2020. Unison believed that staff from the Welsh Blood Service were performing venepuncture without gloves, which Unison was concerned was contrary to Infection, Prevention and Control Guidance. My office was able to speak to the Welsh Blood Service and Velindre about the issue. Initially a detailed written response was prepared to explain the situation and the risk assessments carried out. Ultimately, it was resolved as we facilitated discussions between Unison, the Health and Social Services Group and the Welsh Blood Service.

Professional bodies such as the British Medical Association, the Royal College of Nursing, the medical Royal Colleges

92. I met with representatives from the following organisations during the course of the pandemic:
    a) The Academy of Medical Royal Colleges in Wales on 4 March 2020;
    b) The Royal College of Physicians Wales on 21 May 2020;
    c) The Royal College of Surgeons Wales on 11 June 2020;
    d) The Wales Cancer Alliance on 25 June 2020 and 25 February 2021;
    e) The Association of the British Pharmaceutical Industry on 2 July 2020 and 5 March 2021;
    f) The Academy of Medical Sciences on 20 July 2020.

93. These meetings allowed professional bodies to ask me questions about the Welsh Government's response to the pandemic and plans. It also allowed them to draw to my attention areas of specific concern to them.

94. On 4 March 2020 the Academy of Medical Royal Colleges emphasised the need for the same robustness of 111 lines as there was for 999 lines in terms of capacity and resiliency. We undertook to feed this back to the relevant officials. I exhibit the record of actions produced as a result of that meeting at **M3VGE01/020 – INQ000492733.**

95. The Royal College of Surgeons (on 11 June 2020) explained their concerns over the restoration of surgical services and the disparity in progress across Wales, which was often influenced by the size, location and layout of Welsh hospitals. The meeting was followed with an agreed list of actions provided by me, including an invitation for any ideas they may have for improving patient safety, which I exhibit at **M3/VGE01/021 - INQ000484862**.

a) The Nosocomial Transmission Group would shortly publish guidance on safer patient pathways through hospital admission, including those for surgery.

i. In June 2020 the Nosocomial Transmission Group published a Principles Framework to assist the NHS in Wales to return to urgent and planned services in hospital settings, which I exhibit at **M3VGE01/022 - INQ000299363**

ii. Detailed explanation on the guidance produced by the Nosocomial Transmission Group is included in the witness statement M3-CNO-01.

b) Health Board quarterly plans would continue to be reviewed as regards the segregation of Covid-19 and non-Covid-19 patient flows and the changes to capacity and flow rate occurring as a consequence of enhanced Infection Prevention and Control measures.

i. The role and review of Health Board Quarterly plans has been set out in detail below. In October 2020 Dr Goodall wrote to NHS Chief Executives to set out his expectations in relation to the urgent work required to progress options for the creation of Covid-19-free environments for surgery. He asked that the Local Health Board's Q3/4 operational plans set out the local plans in this area to allow an assessment of how far local plans would take us, which I exhibit at **M3VGE01/023 – INQ000492744**.

c) Wales would pursue a four nations UK approach to development of recommendations for antigen testing in pre-admission patients and asymptomatic staff.

d) I would follow developments in antibody testing with interest.

e) I was keen to hear further ideas for improving patient safety from Royal College of Surgeon members.

f) There were opportunities as well as threats and that the adoption of new ways of working should continue apace. These included decision making on not performing surgery and honesty as to the costs and benefits of particular courses of treatment.

g) I welcomed the professional leadership of the College in advising colleagues on the necessarily difficult conversations with patients that could ensue from this decision making.

h) The Welsh Government would develop the analysis of data by Health Board, on the backlog of patients awaiting surgery.
    i. Please see paragraphs 635-647 of M3-WO-02 for the work on analysing and responding to waiting times, both generally and for specific specialties.
    ii. In particular the Welsh Government monthly statistical publication included figures for pathways waiting on Referral to Treatment which illustrated the backlog of patients waiting.

96. During my meetings with the Wales Cancer Alliance we discussed the effect of the pandemic on cancer services. The Welsh Government worked closely with the Wales Cancer Network to develop expert guidance on the maintenance and recovery of cancer services during the pandemic but also acknowledged the significant impact that the pandemic had on cancer diagnostic and treatment services. Those meetings allowed for specific concerns to be raised. Direct questions were asked and I provided detailed written answers following the meetings. I exhibit an example at **M3VGE01/024 - INQ000484864.**

97. Meetings with the Association of the British Pharmaceutical Industry, summarised at **M3VGE01/025 - INQ000484856** related to the supply and use of vaccines and medicines for the treatment of Covid-19.

Working with the UK Government

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

99. Healthcare is a devolved function with separate governance and funding. Therefore, whilst there was close liaison between all four nations at every level of government, the decisions made and actions taken for the for the delivery of the healthcare system in Wales were made by the Welsh Government and/or by the NHS in Wales. They were not generally contingent upon or reliant upon the UK Government.

100. I had effective working relationships with my counterparts in the other devolved governments. One evening per week the health ministers would speak by telephone or video call in order to share information and discuss matters. These calls encouraged a level of honesty and openness in our discussions that I considered to be very useful. We did not always agree but we were able to speak freely about the challenges that we were facing and understand one another's decisions in response. These discussions were not, however, about operational or even strategic decisions on the delivery of healthcare services.

101. Where issues did arise on which I thought that a Four Nations discussion between Health Ministers might assist I was able to contact my counterparts and request a discussion. I exhibit a draft email at **M3VGE01/026 – INQ000492672** from myself to Matt Hancock MP from 27 March 2020 which was a period in which we were experiencing some supply chain issues, which are set out in more detail below. The note of that meeting shows that I was able to raise the concerns and to receive assurances from Mr Hancock as exhibited in **M3VGE01/027 – INQ000492673**.

102. Ministerial Implementation Groups for four nation discussion forums were established in March 2020 by then Prime Minister, Boris Johnson, in response to Covid-19. The Healthcare Ministerial Implementation Group was chaired by then Health Secretary, Matt Hancock MP. I attended most meetings on behalf of the Welsh Government. The group's key focus was on measures that the Prime Minister had announced to protect public health, measures to increase the capacity of the NHS and deliver cross-government coordination that would be required to deliver social care. Ministerial Implementation Groups did have the benefit of allowing ministers from the four nations to meet to discuss the circumstances we faced and the actions we were taking however decisions about the NHS in Wales were not made in the Healthcare Ministerial Implementation Group.

103. The Ministerial Implementation Groups were short-lived and were drawn to a close in June 2020 when the focus moved to Covid-19 Operations meetings. Officials from the Welsh Government were not routinely invited to Covid-O meetings.

Differences in approach to the UK Government

104. The Inquiry will be aware from evidence in Module 2B that, in general terms and on many issues, the Welsh Government saw a benefit in a consistency of approach across the Four Nations. This was particularly the case for non-pharmaceutical interventions. However, as stated above, as health has been a devolved matter since 1999 and, as will be the case in the other devolved nations of the UK, the healthcare system has developed and evolved based on the ministerial priorities and ambitions of the devolved government.

105. At the start of the pandemic period therefore there were fundamental differences of approach between four healthcare systems in the UK which naturally followed through to the pandemic.

106. During the pandemic the Welsh Government, and myself, made decisions about the provision of healthcare services in Wales based upon the evidence and advice available to us about the circumstances and risks prevailing within Wales.

13 March 2020 Framework

107. The first instance of where there is a significant difference in approach to healthcare was as early as 13 March 2020.

The Framework

108. At 4pm on 13 March 2020, I made a public statement exhibited at **M3VGE01/028 - INQ000198262** explaining that I had agreed a framework of recommended national actions within which local health and social care providers could make decisions in order to provide care and support to the most vulnerable people in our communities, whilst also making sure organisations and professionals were supported to make timely preparations for the expected increase in the number of confirmed cases of Covid-19. The framework did not prescribe how Local Health Boards were required to respond to this framework.

109. The framework included the following actions which allowed for services and beds to be reallocated and for staff to be redeployed and retrained in priority areas:

a. Suspend non-urgent outpatient appointments and ensure urgent appointments were prioritised;
b. Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery);
c. Prioritise use of Non-Emergency Patient Transport Services to focus on hospital discharge and ambulance emergency response;
d. Expedite discharge of vulnerable patients from acute and community hospitals;
e. Relax targets and monitoring arrangements across the health and care system;
f. Minimise regulation requirements for health and care settings;
g. Fast track placements to care homes by suspending the current protocol which gave the right to a choice of home;
h. Permission to cancel internal and professional events, including study leave, to free up staff for preparations;
i. Relaxation of contract and monitoring arrangements for GPs and primary care practitioners;
j. Suspend NHS emergency service and health volunteer support to mass gatherings and events.

110. A further 14 actions were set out in an Oral Statement on 17 March 2020 by the First Minister which I exhibit at **M3VGE01/029 - INQ000271921.**

Reasons for the Framework

111. I am asked about the reasons for this decision and why it was taken on that date. To understand this decision it is necessary to look at the developing picture in March 2020.

112. On 3 March 2020 SAGE summarised the current understanding of Covid-19 and advised that:

a) A single wave was predicted with 95% of cases in peak 9 weeks, 75% of cases in peak 5 weeks and 50% of cases in peak 3 weeks.
b) 8% of infected people would be hospitalised, increasing to 9.81% for those aged 50-59 years, 22.5% for those aged 60-69 years, 36.2% for those aged 70-79 years and 43.79% for those aged 80 and over.
c) 520,000 excess deaths were predicted.

113. On 4 March 2020, I chaired the Cabinet meeting at which this advice was presented and discussed. The Chief Medical Officer briefed Cabinet about the total number of cases worldwide and in the UK. At that time there were 51 cases identified in the UK and only one in Wales. Ministers noted that the spread of the virus would put added pressure on the NHS and the number of potential admissions would equate to a quarter of annual hospitalisations. Local Health Boards were being mobilised, with the potential to create extra beds but an impact on staff numbers was anticipated. A proportionate response was required, and at that moment there was a need to avoid cancelling routine operations and outpatient clinics to help prevent panic. The focus at that time remained on containment and research but planning for the delay and mitigation were already in motion to allow the NHS more time to prepare for the escalation of infection.

114. The first meeting of the Covid-19 Core Group on 11 March 2020 was told that there were 15 cases in Wales, with some community transmission taking place. The policy across the UK remained Contain.

115. The First Minister and I attended COBR on 12 March 2020 at which the UK Government's Chief Scientific Adviser ("GCSA") explained that there were 5000-10,000 cases in the UK and the UK was approximately four weeks behind Italy with the UK epidemic expected to follow the same trajectory. We were moving from the Contain to the Delay phase of Covid-19.

116. During this time, as described in M3-WGO-01, Dr Goodall was meeting with NHS Chief Executives in the days preceding this announcement in which it became clear that departments were losing staff to sickness and there were concerns about staff shortages and the projected increase in Covid-19 case numbers. I exhibit an email from Dr Goodall at **M3VGE01/030 – INQ000492671** following his meeting with me and the First Minister to agree the framework. During that meeting he informed us that, in practice, many organisations were already having to make judgements to cancel routine activities as a necessary response. Local Health Boards were responding to the local circumstances that they found themselves in, and the purpose of the framework was to provide a national framework for such actions rather than a series of different decisions.

117. The decision to introduce this framework of measures was not the result of concerns about capacity in Wales at that time. It was prompted by the move from Contain to Delay and was influenced by the forecasts coming out of SAGE and our awareness of the developing situation in other European countries.

118. With regard to the framework's inclusion of fast track placements to care homes. This related specifically to suspending the protocol which gave them the right to a choice of home and was not related to the testing protocol then in place. At this time the policy in Wales was to test people with symptoms, with inpatient testing a priority, and priority given to ICU patients, followed by those with respiratory conditions and then key workers where capacity existed. There was no policy as of 13 March 2020 to test asymptomatic patients before discharge into care homes. I exhibit at **M3VGE01/031- INQ000337041** a Technical Advisory Cell update to the Chief Medical Officer (Wales) which noted on 16 March 2020 that testing capacity was limited and that Public Health Wales expected testing capacity to reach 5000 tests per day by 6 April 2020.

119. As ever, the most vulnerable in Wales were at the heart of the decision-making process with the briefing noting that '*the overriding priority is to ensure: health protection the safeguarding of vulnerable groups; staff welfare; to ensure NHS and social care preparedness; and systems resilience.*' We were mindful that Wales has a larger older population than the other home nations. This was also reflected in the age profiles within the health and social care workforce. The measures announced above were taken directly to protect those vulnerable groups.

120. Before making this decision, I attended meetings with the NHS Chairs on 13 March 2020 and, subsequently, with the Welsh Local Government Association on 18 March 2020 to ensure that they could feed into the decision-making. Whilst Dr Goodall had been involved in discussions about these measures, this was a significant step for the NHS to take and I wanted to ensure that they were all on board.

Development of the Framework

121. I am asked how this framework was developed and the advice received. On 8 March 2020 I emailed Andrew Goodall and the Chief Medical Officer (Wales) exhibited at **M3VGE01/032 - INQ000479913** expressing my gratitude to those Welsh Government staff who were working weekends and late into the evening. However, I advised that as we entered the delay and mitigate phase, I would want to see further detail on matters such as:

a) the deployment and redeployment of health professionals, the use of junior and trainee staff; and
b) Critical care – its capacity, criteria for admission and the system's ability to staff any new arrangements.

122. Through his Special Advisor the First Minister posed his own questions, which I exhibit at **M3VGE01/033 - INQ000479923,** including:

a) There had been conversations about reopening wards in community hospitals to increase capacity- was this realistic and was the infrastructure available to do it;

b) Did we have the legislative ability to bypass the nurse staff ratios and was the presence of those ratios causing difficulty;
c) Whether the current hierarchy relating to intensive care may become inappropriate;
d) Whether there were alternatives to ventilation available.

123. In response the Health and Social Services Group prepared a detailed briefing, a copy of which is exhibited at **M3VGE01/034 - INQ000479924**. The response from officials confirmed that planning and preparation arrangements had been stepped up, supported by a Covid-19 Programme Director, daily Coordinating Group arrangements chaired by the NHS Wales Chief Executive/Director General, and a planning cell and group working through system issues and risks with high level daily contact with the NHS in Wales, including Chief Executives; all of which fed into the Welsh Government and Emergency Co-ordination Centre Wales planning arrangements.

124. That briefing included the following:

a) Active consideration was being given to what capacity could be reconfigured if routine planned care was temporarily suspended. There was a strong view from Chief Executives that early decisions on freeing capacity through reduced planned and routine work would be welcomed.

b) The option to use demountable ambulance vehicles could provide additional surge capacity - an option which had been successfully used at the Royal Gwent Hospital, and which would offer a minimum six trolley bed capacity along with MRI facilities. This option would bring an immediate and flexible increase in physical bed capacity.

c) Established guidance was already in place in relation to critical care escalation. Further guidance was also in preparation, which included the response planning framework and critical care being covered in the general surge and extreme surge guidance, and that a final draft would be made available to ministers in due course.

d) The starting point was to ensure each Health Board had the options to enhance and increase local capacity, but options to extend critical care capacity required a transfer of patients into a theatre setting, and that the best way to create this capacity was to make decisions to cancel elective in total or on a progressive basis ahead of any predicted demand.

e) It was clear that based on the reasonable worst-case scenario, critical care capacity could not match the level of critical care intervention required to support the Welsh population. The Critical Care Network had been commissioned on 9 March 2020 to undertake modelling scenarios based on the reasonable worst case to work through a series of actions given what was described as a significant shortfall in capacity. The expansion plans included bed numbers, equipment, redeployment and training of staff, and admission criteria. I was advised the Network was also collating ventilator numbers and was scoping what equipment could be redeployed and any additional equipment requirements.

f) The Welsh Government was fully engaged in a UK-wide approach to procurement of equipment and items that supported the ventilation needs of patients and the critical care expansion plans. This work was supported by a baseline audit.

g) Critical care resource was to be prioritised for those with multiple organ failure; those with single organ failure were likely to be managed with the relevant specialty, such as renal and respiratory failure. At the stage when critical care capacity was exceeded, prioritisation would be based on triage by resource, utilising triage criteria such as the Sequential Organ Failure Assessment, and the patients' chances of survival.

h) I was informed that all Health Boards had plans in place to double critical care capacity (based on the updated Welsh Government guidance issued in 2017). I was advised Health Boards regularly surged in capacity and plans to double capacity were implemented and tested during the winter flu

outbreak in 2010. Those plans also tested and informed our approach to guidelines for the treatment of severe respiratory failure.

i) In Wales there were 145 (level 3 equivalent) general adult critical care beds but I was advised that we were less able to scale up pediatric and neo-natal critical care capacity. A further meeting was to be held to review pathways and resourcing. The view at that time was that the system could scale up quickly, but the difficulty was maintaining this over a prolonged period. Alternatives to ventilation, such as non-invasive ventilation, were also to be undertaken by respiratory physicians. However, the briefing stated that this capacity was likely to be saturated relatively quickly and further actions through the Critical Care Network were required.

j) Training competencies were also being explored in addition to what support universities could offer to upskill staff.

k) Officials were actively exploring the provisions within the then Coronavirus Bill around issues such as emergency registration and the relaxation of some of the requirements of the DBS checks across the health and social care sectors. The purpose of which would allow the NHS to bring recently retired individuals or additional workers into the system as quickly as possible.

l) Work was underway around how the Welsh Government could maximise flexibility to ensure the workforce could be deployed across Wales as demand varied. Officials were engaging with the NHS Wales Shared Services Partnership to ensure we were prepared for the rapid addition to the payroll for new staff and other practical pay and employment type issues. Health Education and Improvement Wales was considering ways to deploy junior and or trainee staff.

m) The Wales Council for Voluntary Action and the third sector were engaged in the work undertaken by the Welsh Government to explore the actual

capacity within the sector and the opportunity for volunteers to provide support.

125. I am asked what advice I received in the preparation of the 13 March 2020 Framework. I was assisted by a briefing on Systems Risks Issues by the Covid-19 Planning and Response Group- I exhibit this as **M3VGE01/035 – INQ000299010**. The briefing noted that the national Pandemic Flu plan provided a framework of actions and that every health organisation had an extant plan which they had been in the process of reviewing and amending the preceding month. The systems risks and issues outlined included:

a) **Acute Hospital Capacity** - There was growing consensus amongst the clinical community in the NHS in Wales that acute hospital capacity should start to be released in a phased way. This would ensure that preparations could be put in place for the early cohort of vulnerable, non-Covid-19 patients, as well as releasing capacity that could be reconfigured to cohort Covid-19 patients and to create additional critical care capacity. Phasing the release of acute capacity would also facilitate the early redeployment and training of staff to allow this to happen in a planned way.
b) **Critical Care** - The reasonable worst case modelling indicated a 30 fold increase requirement in the availability of critical care beds. Action was required to create significantly increased levels of beds, equipment and staff.
c) **Hospital Discharge** to ensure patients were in the most appropriate and safe settings.
d) **Primary and Community Care**
e) **Workforce Deployment and Welfare**

Impact of the Framework

126. I am asked about the impact of this framework on hospital capacity in the first wave of the pandemic. That cannot be quantified. This systems risk framework was formally reflected in Ministerial Advice MA/VG/1004/20 dated 20 March 2020, exhibited earlier in **M3VGE01/015 - INQ000366593** which repeated that the framework set out national

actions that were recommended for local implementation by the NHS in Wales and social care providers.

127. The advice did not provide a model or estimate of the number of beds that would or could be released by taking actions such as those included within the framework. Each individual Health Board had the discretion and the duty to implement this framework by identifying the actions that were required based on the circumstances and demographic of its local population. For example, the framework did not specify the period of time for which surgery or appointments were suspended. It would not have been possible to produce calculable quantitative estimates of the effect of these actions.

128. Furthermore, this framework was just one action during a period of time when a large number of decisions were made and actions taken to increase capacity within the NHS in Wales it would not therefore be possible to divide and identify the impact of this framework alone. However, without the framework our NHS could not have both reduced regular work in an orderly manner nor surged to increase capacity (e.g. critical care).

129. The extent to which the delivery of routine services could be resumed was reviewed and described in each of the quarterly Operating Frameworks described above. That was always a matter for local decision based on an assessment of what could be done safely and without compromising our ability to respond to Covid-19 patients and deliver essential services. Professional bodies, such as the Royal College of Surgeons, developed guidance and checklists to inform these decisions.

130. In December 2020 Dr Goodall wrote to Chief Executives, Local Health Boards and Trusts exhibited at **M3VGE01/036 - INQ000083248** together with a local options framework for routine services exhibited at **M3VGE01/037 - INQ000083247** which recognised that there were, at that time, concerns about system pressures across urgent and emergency care. Once again, the framework was a means to facilitate Local Health Boards and Trusts to make their own decisions based upon local circumstances and pressures. I exhibit a spreadsheet collating the responses received to this request as **M3VGE01/038 - INQ000083249**.

Shielding

131. The shielding programme was introduced by the Welsh Government on 16 March 2020 and ended on 31 March 2022.

132. Early in the pandemic, members of the public were identified by health professionals as being clinically vulnerable ("CV"). The four national UK Chief Medical Officers, advised by clinical leaders, agreed the clinical criteria for those who were at even higher risk, the clinically extremely vulnerable ("CEV"), who would be to be advised to shield. The clinically extremely vulnerable individuals were identified based on the severity, history and treatment levels of their condition(s) and collated in a list referred to as the shielding patient list ("SPL"). The Welsh Government's role in the shielding programme is summarised at paragraphs 674- 742 of M3-WGO-01.

133. The Chief Medical Officer (Wales) took the lead, on behalf of the Welsh Government, in the identification of the relevant medical conditions, the shielding policy and guidance and the shielding advice (see M3-CMO-01). I was provided with regular updates from him on this process but did not take any decisions on their suitability. I cannot, therefore, comment on the reasons for any divergence in the health conditions identified as clinically extremely vulnerable or differences in the guidance and advice for those shielding.

134. When 'shielding letters' were sent to provide advice to those at highest risk of coronavirus I did see the letter but ultimately the view was that it ought to be sent on behalf of the Chief Medical Officer rather than myself and I agreed with that.

135. Any key decisions I was asked to take in respect of the shielding were via a Ministerial Advice, with advice from officials and the Chief Medical Officer (Wales) included. On 5 May 2020 I issued a Written Statement providing an update on shielding in which I explained that following a refinement of the medical criteria for shielding, and in line with the other three nations, the Chief Medical Officer (Wales) would be sending letters to further high risk patients. I exhibit this Written Statement

at **M3VGE01/039 – INQ000492678**. Those letters advised people to shield until at least 15 June 2020.

136. In MA/VG/1763/20 dated 29 May 2020 and exhibited at **M3VGE01/040 – INQ000144908** I was asked to consider options for those on the shielding list in light of the relaxation of lockdown measures and the Chief Medical Officer's advice. He presented 4 options:

a) No change to the advice with individuals to remain shielding;
b) General information to be provided to those shielding, emphasising that recommending isolation was advised in order to minimise their potential for acquiring infection when there were high circulating levels of the disease.
c) To give more specific messaging including encouraging exercise outdoors, encouraging strict social distancing, and avoiding peak times of the day, as well as to encourage socially distanced interaction with another household outdoors.
d) Wholesale relaxation of shielding.

137. Officials advised that I accept Option C above which would include a letter being issued to those in the shielded cohort advising them of the relaxations. The UK Government had made an announcement indicating that it would wish to introduce these relaxations with a view to considering whether shielding could be discontinued entirely in the coming months. However, the advice from the Chief Medical Officer (Wales) was that he believed the UK Government was not being sufficiently cautious and he was in favour of extending the shielding programme until 16 August 2020. I followed the advice of the Chief Medical Officer and decided to extend the shielding programme. His advice has been previously exhibited above in **M3VGE01/040 – INQ000144908** and I made a public statement on 1 June 2020 explaining this decision at **M3VGE01/041 – INQ000480048**.

138. On 1 July 2020 I received MA/VG/2163/20, exhibited at **M3VGE01/042 - INQ000136796** on the Next Steps for Shielding in Wales. I was asked to pause shielding from 31 July 2020 to align with the advice from other nations and to allow a maximum period without restriction across the summer months. I decided again to

continue with shielding until 16 August 2020, which I exhibit at **M3VGE01/043 - INQ000252524**. I understand from evidence submitted to the Inquiry that this difference in approach had the potential to be confusing, however I had received an email from the Deputy Minister and Chief Whip concerning input from the Disability Equality Forum about the need for adequate warning of changes. I was concerned that moving to the earlier date was fraught with difficulty and that people felt abandoned rather than liberated by being taken out of shielding, which I exhibit at **M3VGE01/044 - INQ000252522**. I exhibit my Written Statement on this decision from 16 July 2020 at **M3VGE01/045 – INQ000262466**

139. On 9 October 2020 I received MA/VG/0358/20 exhibited at **M3VGE01/046 - INQ000145015**. As levels of Coronavirus were increasing across most areas of Wales, for those who were clinically extremely vulnerable and on the shielding patient list the four UK Chief Medical Officers were advising that shielding should not be reintroduced. Based upon the advice received I did not consider it necessary to reintroduce shielding but agreed that a letter should be sent to those on the shielding patient list with advice on how to keep safe and manage their own risk. I exhibit a Written Statement on 22 October 2020 at **M3VGE01/047 – INQ000048754** in which I updated that the Chief Medical Officer (Wales) had written to those who were extremely vulnerable in order to advise them on how to protect themselves.

140. On 16 December 2020 I received MA/VG/4464/20 exhibited at **M3VGE01/048 - INQ000136830** which provided a letter from the Chief Medical Officer (Wales) in relation to the clinically extremely vulnerable forming Christmas bubbles. It also updated this group on the specific advice they should follow in relation to each alert level contained within the Coronavirus Control Plan for Wales. This was soon overtaken by events and shielding was reintroduced on 22 December 2020. I made a public statement exhibited at **M3VGE01/049 - INQ000321032** to explain that this decision had been taken based on number of factors but had been influenced most recently by the significant recent growth in rates of infection, possibly due to the new variant of the coronavirus. We also took account of the pressures on our health service experiencing increasing hospitalisations.

141. On 18 January 2021 I received MA/VG/0243/21 exhibited at **M3VGE01/050 - INQ000235912** which provided the latest advice from the Chief Medical Officer (Wales) in relation to the clinically extremely vulnerable. This group was advised not to attend work or school outside the home until 7 February 2021 and the advice recommended maintaining shielding measures until 31 March 2021. I accepted this advice.

142. On 5 March 2021 I received and accepted advice that shielding should be paused on 31 March 2021 in MA/VG/1068/21 at **M3VGE01/051 - INQ000136846**. I issued a Written Statement exhibited at **M3VGE01/052 – INQ000353432** on 1 April 2021 that, in view of the decreasing case prevalence, the Chief Medical Officer (Wales) recommended that the advice to the clinically extremely vulnerable to follow shielding measures was paused from 31 March 2021.

143. On 19 August 2020 the Welsh Government carried out an Integrated Impact Assessment *"Impact of Shielding on Vulnerable Individuals: Integrated Impact Assessment"*. I exhibit a copy of this document at **M3VGE01/053 - INQ000066205** which concluded that:

a) The proposal had been developed at pace to respond proportionately and effectively to developing events in respect of Covid-19. The actions had been supported by Ministerial decisions, and senior leads across the Welsh Government, as well as by Strategic Budgeting, Star Chamber and Welsh Ministers. This wide range of stakeholders had ensured that those affected by the proposal have been adequately represented in its formulation. The Welsh Local Government Association and Wales Council for Voluntary Action had been involved in developing and implementing the proposal.

b) The most significant impact was positive, with the creation of a robust system of governance that provided assurance that access to services and provisions continued for those who identified as extremely vulnerable/shielding. There was a real risk to the health and well-being of isolated shielding individuals without this programme, as not providing priority access to food, medicines, social and other services could lead to

people risking their health to leave their homes and shop and/or going without food, medicines and essentials. There was a significant impact re: cost but this was fully taken into account and was considered proportionate as part of an emergency response to the pandemic.

c) The main thrust of the proposal helped to achieve the Welsh Government's well-being objectives and the well-being goals. In turn, this supported the objective of creating a prosperous Wales by

   i. providing the necessary support and assurance to citizens;
   ii. by enabling them to access the provisions and services available to comply with the Welsh Government's shielding advice;
   iii. getting provisions and correct medication to extremely vulnerable citizens as and when they needed it, thus minimising the potential negative impacts during the pandemic;
   iv. enabling volunteers efforts to be at maximum efficiency, building in their trust in the ability of the Welsh Government to deliver for citizens; and
   v. bringing all of these groups together with the Welsh Government, as well as local authorities, the Welsh Local Government Association, the Wales Council for Voluntary Action and Community Voluntary Councils, in a spirit of collaboration that would help to grow community spirit, protect and enhance well-being and leave individuals in the Shielded group feeling less vulnerable to worsened mental and physical health and isolation.

d) Not implementing the proposal could have led to shielding individuals not obtaining the services and provisions they required, or to them breaking self-isolation guidelines to access the food, medicines and essentials they needed.

e) Both outcomes could have led to individuals having significantly worsened mental and/physical health, including a greater likelihood of contracting Covid-19; this could in turn put more pressure on health services. Further

to this, not fully utilising the capacity provided by businesses, local authorities, volunteers and other organisations could have led to reputational damage to the Welsh Government in terms of how effectively the public perceived the response to have been.

144. The "*Shielding lessons learned review- March 2020 to June 2021"* was carried out by the Welsh Government on 9 August 2021 and aimed to identify strengths and areas for improvement from the programme to learn from the experience of implementing 'shielding' policy. Its findings were addressed to an operational level within the Health and Social Services Group. I exhibit a copy of this document at **M3VGE01/054 – INQ000066553**. Conclusions were reached on the following themes:

a) **Collaboration** –

i. Many respondents identified collaboration between colleagues, Ministers, local authorities and internal and external stakeholders as very positive, with particular emphasis on strength in working together to achieve a common goal.

ii. Collaboration was stronger in some areas than others. Relationships between the Welsh Local Government Association/Wales Council for Voluntary Action and the Welsh Government had an existing foundation of partnership. This group also facilitated the sharing of information and a collective sense of responsibility and accountability.

iii. Relationships were less well established with Digital Health and Care Wales and recognising this, a co-ordination role was established by the NHS Delivery Unit - acting as an intermediary between Digital Health and Care Wales and Welsh Government colleagues. This lack of an established relationship prior to the pandemic, limited resources in both Digital Health and Care Wales and Welsh Government health policy and the limited understanding within the Welsh Government of the mechanisms/ways of working within Digital Health and Care Wales meant that when an element of delivery went wrong, there was less support in place for colleagues working as part of a shared endeavour.

b) **Resourcing** -

i. Resourcing was a key challenge at the start of the pandemic, due to very short timeframes required for emergency response and insufficient numbers of staff to be diverted to the task. This led to staff working long hours, including evenings and weekends, on a regular basis over a number of weeks and concern was expressed that this way of working felt unsustainable.

ii. When shielding policy moved within the Health and Social Services Group in May this coincided with priority resourcing being placed on a more established footing across the Welsh Government, thus despite continuing with long working hours, for the first time the main policy function was properly resourced. However, for teams in other organisations the resourcing position became more challenging as people were asked to take on more of their previous work or were diverted to other pandemic priorities.

c) **Data sharing** -

i. Implementing data sharing arrangements was a significant challenge due to the complex data pathway and legislative context involved. Establishing the approach to data flows for the Shielding Patient List was a key early success.

ii. Use of emergency Covid-19 legislation made it possible to share data with a range of bodies and companies critical to supporting vulnerable people (local authorities, food box suppliers, pharmacies, supermarkets, utility companies) in a rapid timescale.

iii. There were existing data agreements and processes in place which helped facilitate the sharing data. However, some local authorities who had not previously used the selected system reported some frustration.

iv. There was also a lack of alignment for data sharing formats and processes across the wider Covid-19 response, increasing workload for colleagues in Digital Health and Care Wales, due to

varying format requirements between different teams working on aspects of Covid-19 response.

v. Identifying the correct lawful basis was a key barrier requiring substantial resource and expertise to resolve.

vi. The differing approaches between Wales and England were also challenging to work through at times. To make this easier for the future, officials should work with UK Government to consider legislative arrangements that could enable greater flexibility of response, such as pursuing an 'emergency response' objective for the data sharing powers in the Digital Economy Act. Colleagues also faced technical challenges relating to the coding of health record data.

vii. This impacted capability to answer queries about specific conditions. Changes made to improve documentation of codes made by Knowledge and Analytical Services (KAS) aided the process.

d) **Communications –**

i. The main method of communicating with individuals on the Shielding Patient List was through sending letters containing advice from the Chief Medical Officer (Wales) directly to individual addresses, while also, for later versions, publishing the content of the letter online.

ii. During periods where shielding advice was in place, letters fulfilled a legal requirement that a notification was issued, for the purposes of eligibility to statutory sick pay.

iii. Letters also ensured that digitally excluded individuals were able to access advice easily. The requirement to issue a physical letter presented challenges – the contact information held about individuals through GP systems was sometimes incorrect and in the original issue of letters a significant number were misdirected due to the manual process required for list management. The production of letters took time both in terms of drafting and appropriate clearances and subsequently in printing, sorting and distribution.

From the announcement of a letter to doorstep took a minimum of two weeks which was not ideal considering the immediacy of the message some of the letters needed to convey. As time went on, processes across organisations were agreed.

iv. Publication of letters was prioritised in English and Welsh only initially and this resulted in some poor feedback around accessibility of messaging. Accessible versions were then made available online and provided on request for each letter issued.

v. To provide as much assistance as possible and in response to feedback from the Disability Equality Forum, all letters were then produced with an easy read section at the start and end of each letter offering sources of support. Other sources of communication with the public included strong media coverage and interest. This helped to ensure a large degree of public awareness of the support available for people on the Shielding Patient List.

vi. However, while the policy intent was to align on shielding policy across all four UK nations, cases where approach diverged led to confusion between national and devolved government messaging.

vii. From June 2020 onwards, stakeholder forums consisting of representatives from third sector groups, local authorities and Community Voluntary Councils were held virtually on an ad hoc basis when there were new updates to advice and to inform guidance development. These provided a space for the Welsh Government to share and receive information. This two-way relationship supported policy officials to be able to respond to the needs of the shielding community, while clarifying any areas of ambiguity or consolidating understanding.

viii. Additional challenges for communicating a clear narrative included confusion around whether shielding measures were advice or legal measures, as well as the role of GP surgeries in providing advice (while GP surgeries were provided with guidance and a template of the letter to issue if required, patients were often redirected to contact the Welsh Government instead). Instigating a central

contact mailbox helped to alleviate some of this difficulty, as policy officials were able to respond directly to individuals with concerns.

e) **Service Provision -**

i. The speed at which services such as pharmacy and food boxes were established stood out as a positive achievement. The pharmacy service, which recruited volunteers to help deliver medications to shielding individuals, was set up over a five-week period (an exceptionally rapid timescale compared to pre-pandemic procurement exercises). It included a clear audit governance trail despite the large number of contracts required. Consideration was also given to future planning, with potential for extension embedded into contracts from the outset.

ii. Food box services were also introduced in a short timescale, with national contractual and delivery arrangements set up within two weeks, despite the complexity of the process. These could be requested from local authorities and were delivered weekly to people's doors. However, substantial challenges were associated with this service. Partners such as local authorities and Strategic Co-ordination Groups critiqued the quality of food provided, while some local authorities asked to receive funding directly rather than through the nation-wide scheme.

iii. Cross-border communication difficulties were encountered with food boxes provided from England. Catering for dietary requirements was not possible under the initial scheme, which impacted people with religious and disability-related (or other dietary preference) requirements, although some local authorities introduced the ability to adapt food boxes later in the pandemic.

iv. The food boxes had been a national contract. There was lack of control with accuracy of where, when and what was delivered due to the scale of the contract. As the weeks went by, and to ensure effective delivery of the food boxes, both Ceredigion and Carmarthenshire piloted their own food box scheme to ensure quality food was delivered at the right time and to the right place.

Supermarkets developed their own food box scheme (at a cost) which made it easier for others who were not on the Shielding Patient List to have access to essential food, without the issues of working through an online order.

f) **Organisational Infrastructure –**

i. As with other elements of coronavirus response, organisational frameworks for response were not sufficiently in place pre-pandemic, and therefore were constructed at the same time as delivering the response itself. For shielding this was further exacerbated by the intervention itself being completely unique, with no obvious lead policy owner. This is an unfamiliar way of working within civil service structures, where large projects or programmes often feature planning phases prior to any delivery being conducted. As a result, various infrastructural challenges were encountered.

ii. Some of these challenges were overcome by identifying a shielding team within the Health and Social Services Group in the Welsh Government and setting up a central shielding mailbox. The team worked to overcome the backlog of public and ministerial enquiries. They also engaged and worked closely with stakeholders, such as Learning Disability Wales, to improve the accessibility of information provision, such as through adapting standard publication formats to include 'Easy Read' translation.

145. The report made the following recommendations:

a) Actions for the shielding team:

i. Produce a high-level stakeholder organogram

ii. Ensure a clear point of contact was available for recipients of shielding advice. This could take the form of a contact centre. GPs should also be aware of this contact point, as well as specific guidance for them in how to support patients advised to shield.

b) Actions for the wider Welsh Government:

i. Incentivise flexible resourcing opportunities so that people could adapt to crisis when needed. Recognise longer term impacts of crisis ways of working and prioritise securing sufficient staffing resource for support.
ii. Identify and communicate clear governance and reporting structures and decision-making processes at the outset and maintain these.
    1. This should extend to the four-nation level, including with clinical governance structures.
iii. Prioritise strong working relationships with stakeholders
    1. Include local authorities and Community Voluntary Councils in forums from the start.
    2. Establish good working relationships with counterparts in other UK nations.
iv. Prioritise use of accessible formats, including providing easy read alternatives as standard and translation to other languages as appropriate (including BSL).
    1. Ensure appropriate expertise was in place to advise on complexities of translating medical language.
    2. Utilise 'call-off contracts' for translation.
v. Work with the UK Government to pursue an 'emergency response' objective for the data sharing powers in the Digital Economy Act to aid in the response to future emergencies.
vi. Consult the Information Commissioner's Office, if necessary, as a reassuring advisory source.

c) Actions for future similar pandemic response teams:
    i. Have desk instructions in place to ensure consistency. This could include useful lessons learned – e.g., that when sending queries, grouping them could be helpful - checking a list of 20 may only take slightly longer than checking one, but save a lot of time overall.
    ii. Align policy approaches across UK nations to support consistency of messaging.

iii. Critically review stakeholder engagement and governance structures periodically to identify any areas of omission (important to ensure representation from health and local authorities).

The effect of decisions upon people with disabilities, the clinically vulnerable and clinically extremely vulnerable, those from minority ethnic backgrounds or lower socio-economic backgrounds, and those with existing health inequalities

146. In Wales we have committed to progressing a more equal Wales reflecting this in the statutory duties on our public bodies and in the development and delivery of policies. Equality and human rights have always been central to the work of the Welsh Government and our vision for Wales, including tackling stubborn structural inequalities in Wales.

147. The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 requires public bodies, including the Welsh Ministers to consider how they can positively contribute to fairer society through advancing equality and good relations in their day-to-day activities. In 2011, Wales also became the first country in the UK to incorporate children's rights into domestic law with the introduction of the Rights of Children and Young Persons (Wales) Measure 2011. The Measure requires the Welsh Ministers to consider children's rights in everything they do.

148. The Wellbeing of Future Generations Act 2015 also sets out Health and Equality as two main goals. The Act sets out seven well-being goals for national government, local government, Local Health Boards and other specified public bodies which includes the goal of a more equal Wales meaning having a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio-economic background and circumstances).

149. The Welsh Government's Strategic Equality Plan 2020-2024 was published in April 2020, a copy of which is exhibited at **M3VGE01/055 - INQ000350655** and reducing inequalities in health and wellbeing was a key theme of both 'Prosperity for All' strategy exhibited at **M3VGE01/056 - INQ000187588** and 'A Healthier Wales'.

150. During the pandemic, these statutory duties did not disappear, nor did our commitment to progressing to a more equal Wales, and these considerations formed an important part of the Welsh Government's response to the pandemic in terms of understanding direct and indirect impacts. We were conscious of the significant impact the health care system could have upon groups such as disabled people, those who are clinically vulnerable, Minority Ethnic people and those with poor socio-economic backgrounds or with existing health inequalities.

151. The Welsh Government published the approach it would take in assessing whether and when conditions enabled specific lockdown restrictions to be eased in "Leading Wales out of the coronavirus pandemic: a framework for recovery" on 24 April 2020 and "Unlocking our society and economy: continuing the conversation" on 15 May 2020. Both these documents embodied the Welsh Government's commitment to ensuring decisions to ease lockdown restrictions sought to deliver a 'high positive equality impact'.

152. Equality impact assessments are an important part of policy making, and the Welsh Government has either statutory obligations or has made commitments for the consideration of a number of areas of impact when developing policy. Throughout this period decision making by the NHS in Wales and Welsh Ministers continued to be assessed against their statutory duties. The Welsh Ministers and the NHS in Wales were required to undertake an equality impact assessment as part of their duties under the Equality Act 2010, however, due to the pace of the decisions required, particularly at the start of the pandemic, it was not always possible for formal published impact assessments to be produced alongside decisions as they were made. A list of the published Impact Assessments is exhibited in **M3VGE01/057 - INQ000227405**.

153. Equality impact assessments of note are referenced here for ease but further detail has been included in M3-WGO-01 at paragraph 109;

a) Equality impact assessments prepared for the 21-day reviews of the Covid-19 measures, an example is available at **M3VGE01/058 - INQ000087135**;
b) Equality impact assessments which considered the impact of shielding on vulnerable individuals, previously exhibited at **M3VGE01/053 - INQ000066205**;

c) All Wales Covid-19 Workforce Risk Assessment Tool: integrated impact assessment which I exhibit at **M3VGE01/059 - INQ000023242**.

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

155. We were proactively collating, logging and summarising the key themes from a range of reports, briefings and insights in relation to the impact of Covid-19 on people with protected characteristics in Wales. This data was able to be used by officials when preparing equality impact assessments for a wide range of decisions across the Welsh Government, and particularly in respect of the 21-day reviews.

156. In making decisions the Welsh Government engaged the All-Wales NHS Equality Leadership Group, as well as others where possible to ensure consideration of equality issues as part of the process despite the absence of a formal Equality Impact Assessment ("EIA"). Early in the pandemic the Equality Leadership Group considered the disproportionate effect that Covid-19 infections were having on health and care professionals from Black, Asian and Ethnic Minority backgrounds.

157. To ensure that we were making informed decisions that were in the best interests of the most vulnerable and the most affected in Wales the Welsh Government established the following groups;

a) The Black, Asian and Minority Ethnic Covid-19 Advisory Group,
b) The Covid-19 Moral and Ethical Advisory Group for Wales

158. The Black, Asian and Minority Ethnic Covid-19 Advisory Group included representation from Welsh Government officials; Black, Asian, Minority Ethnic NHS

and care workers; Public Health Wales; and Local Health Boards and Trusts; and drew in expertise from those involved with data collection and analysis, workforce management, occupational health, quality and safety, academic, and any other additional expertise as required. The work of the Advisory Group informed and helped protect the health and wellbeing of our communities, and provide more tailored advice for health, social care and other workers.

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

160. The remit of the Risk Assessment Subgroup was primarily to consider the evolving evidence, in order to make recommendations to the First Minister's Advisory Group on a workplace risk assessment for frontline health and social care workers in Wales. The Risk Assessment Subgroup considered a range of approaches to risk assessment drawing on existing tools in use elsewhere as well as a wide range of evidence and numerous reviews. The group concluded that it was a combination of various factors which contributed to the severity of infection including age and ethnicity. This led to the production and refinement of the All Wales Covid-19 Workforce Risk Assessment Tool, a simple, easy to use, self-assessment tool designed to be suitable for use for all health and social care staff, regardless of ethnicity. A copy of the tool is exhibited previously at **M3VGE01/059 - INQ000023242**. The Tool includes signposts to health and wellbeing resources as well as the existing and continuing behaviours to avoid Covid-19 infection. The tool was further amended to suit the context of different workplaces, with a sector specific version available for education as well as a more generic version for 'other sectors.' This tool was presented to me as part of MA/VG/1635/20 which I exhibit at **M3VGE01/060 - INQ000144893** and I agreed its launch.

161. This tool fell to be amended in December 2020 when clinically extremely vulnerable staff were advised to return to shielding. The Chief Nursing Officer heard and communicated the concerns of Nurse Directors about how it would affect their staff which I exhibit at **M3VGE01/061 - INQ000412533.** The Unions position was that the clinically extremely vulnerable should have just been told to stay at home.

Ultimately the decision fell to me and in exhibit **M3VGE01/062 - INQ000412534** I concluded that individuals should be permitted to determine how the shielding advice applied to their own particular circumstances.

162. The terms of reference for the Risk Assessment subgroup also included consideration of the approaches in other UK countries and to recommend any interventions to protect against Covid-19, including implications for workforce and safe, effective PPE usage. In the report of the subgroup published October 2021, the risk assessment subgroup observed that those from Black, Asian, or Minority Ethnic groups may face bullying and microaggressions regarding PPE availability and be more reluctant to speak out regarding PPE availability. A copy of this report is exhibited at **M3VGE01/063 - INQ000082919**[2].

163. On 22 June 2020, the Socioeconomic subgroup produced a report highlighting the disproportionate impact of the pandemic on minority ethnic communities, a copy of which is exhibited in **M3VGE01/064 – INQ000227599**. The report made 37 recommendations, with a small number relating to the healthcare sector.

164. The Welsh Government published a detailed response to the report's many recommendations on 24 September 2020. I exhibit the First Minister's Written Statement at that time at **M3VGE01/065 - INQ000023260** and the Welsh Government response at **M3VGE01/066 - INQ000300238**. This confirmed the Welsh Government's implementation of the recommendations, that action in relation to many was already underway, had been completed or commitment had been made by the Welsh Government to take further work forward. The recommendations formed an integral part of the Welsh Government's Race Equality Action Plan for Wales. In addition, the Welsh Government immediately confirmed its long-held commitment to advancing equality for all. Many of the recommendations were addressed by the 2022 Anti-Racist Wales Actions Plan, which I exhibit at **M3VGE01/067 - INQ000227788**. For completeness I also exhibit the 'Anti-Racist Wales Action Plan – A Year On' annual report for 2022-2023 at **M3VGE01/068 - INQ000480730**. The key June 2020

[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 [INQ000282020].

recommendations related to the healthcare sector, and the and the actions taken by the Wesh Government in response, including those in the Anti-Racist Wales Action Plan, are set out below. The implementation of these recommendations was led by Welsh Government officials and, where set out below, Public Health Wales. In relation to the actions taken forward by the Anti-Racist Wales Action Plan, these were led by the Minister for Social Justice, Jane Hutt, with some actions agreed and signed off by Cabinet.

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

    i. The Anti-racist Wales Action Plan (ArWAP) established a Workforce Race Equality Standard (WRES) for Wales to measure disparities in the experience of our Black, Asian and Minority Ethnic workforce in progression, leadership, bullying, harassment and discrimination. The WRES data will provide a means to measure disparities in the experience of our Black, Asian and Minority Ethnic workforce in progression, leadership, bullying, harassment and discrimination. The first standardised data collection in April 2024 of directly employed NHS staff has identified where gaps in ethnicity data still exist, with further data collection scheduled for the autumn and a national report due to be published in September 2024. Targeted actions to address gaps will be identified with each of the NHS Health Boards, Trusts and Special Health Authorities. Their resulting anti-racism action plans will be scrutinised through existing accountability structures, with NHS organisations required to evidence their anti-racism approaches for both employment and service delivery. The Welsh Government has also established a new NHS Health Inequalities Group to work to ensure the recovery from the pandemic is inclusive. The Group will draw on lived experience to identify barriers Black, Asian and Minority Ethnic

people experience in accessing health services and making recommendations for improvement.

b) *Ensure wide dissemination of the risk assessment tool backed by robust employer and employee advice in a range of formats, supported by clear and time-bound communication and stakeholder engagement plan.*

   i. The Workforce Risk Assessment Tool was immediately made available to health and social care employers by way of direct contact supported by official announcement by the First Minister and Health Minister on 20 May 2020. Immediately following this, versions for health, social care, education and other settings were made available on the Welsh Government's website. A guidance document and FAQ document were additionally available for NHS staff along with an easy read version. NHS employees were able to complete the tool through the electronic staff record platform while social care, contractual NHS employees and other professions were able to access the interactive version online through the national e-learning platform. The implementation of the tool was supported by a comprehensive communication plan for the health and social care sector and was integrated as part of a wider cross cutting communications strategy which continued to develop as it was rolled out wider. More than 71,000 NHS/social care employees and over 74,000 public sector employees used the online version of the tool, with an estimated 45,000 additional paper versions downloaded and used. Iterations of the tool were notified to NHS Employers directly.

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

i. The health measures within the Anti-Racist Wales Action Plan described above and below seek to address any unfair or illegal discrimination at or by the NHS in Wales.

ii. The work of the Socio Economic Group suggested that the lived experience of some Black, Asian and Minority Ethnic members of the workforce was that the policies in place to support individuals to raise concerns in the workplace and to address issues where they have experienced bullying and harassment were not fit for purpose, and individuals may not have felt confident to use the policies for fear of negative consequences. The NHS Wales Framework for Speaking up Safely was published in 2023 and strengthened the existing all-Wales procedure for raising concerns. In conjunction with the recommendations from the independent audit of all-Wales NHS workforce policies, there are clear expectations on NHS organisations to ensure that staff can speak up on issues including racism without fear of detriment.

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

i. The health chapter of the Anti-racist Wales Action Plan outlined the commitment to ensure that NHS Wales organisations demonstrate strong anti-racist leadership, and that staff can work in safe, inclusive environments. Black, Asian and Minority Ethnic NHS staff, Trade Unions, employers and the members of the existing NHS equalities networks have been involved in the implementation of these actions to take forward these recommendations on a consistent national basis since its publication in 2022. Employers and tripartite policy groups are expected to respond to recommendations from an independent audit of NHS Wales workforce policies through an anti-racist lens in line with priorities

identified through the 2024 Workforce Race Equality Standard (WRES) report.

ii. The Anti-racist Wales Action Plan outlines expectations of NHS Boards to ensure staff networks meaningful input into organisational planning and scrutiny. The Speaking up Safely Framework (2023) outlines expectations for NHS Boards to be monitoring workforce complaints and concerns raised by protected characteristics and to address barriers to ensure seldom heard staff can speak up without fear of detriment. Data from the NHS Staff Survey will also provide annual data to monitor staff experience of speaking up.

iii. As noted above, data has been collected and analysed on NHS Wales staff race and gender as well as lived experience across all thirteen NHS Health Boards, Trusts and Special Health Authorities, with further data collection and a national report due in September 2024.

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

i. Ethnic Minorities and Youth Support Team Wales (EYST), working in partnership with Women Connect First, Henna Foundation, ProMo Cymru, Wales TUC, and key Black, Asian and Minority Ethnic stakeholders received funding from the Welsh Government via the Voluntary Services Emergency Fund managed by WCVA to deliver the helpline, initially as a six-month pilot project. EYST subsequently obtained partnership funding and the helpline is still in operation, now called the Multi-language Helpline Wales.

f) *Develop a clear multi-channel communications strategy for health and social care in partnership with Public Health Wales, Welsh NHS Confederation and ADSS or SCW for social care and minority ethnic*

communities, which identifies effective channels to disseminate information and includes funding for targeted outreach and consultation activities.

i. The Welsh Government's Test, Trace and Protect (TTP) programme developed a Black, Asian and Minority Ethnic Outreach Plan to be delivered by Health Boards in Wales, with outreach workers engaging directly with Black, Asian and Minority Ethnic people and communities and materials produced in a wide range of community languages to ensure that there is wide access to essential. Communications on "Keep Wales Safe" were also translated into 36 languages.

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

i. A Screening Engagement Team within Public Health Wales has the specific role of raising awareness of screening and promoting informed choice. The team works across all screening programmes and with the whole population but targets its efforts particularly at groups and communities where uptake is low. The screening programmes also work with third sector and community groups on more targeted screening campaigns. Public Health Wales also has a Screening Inequalities Group which looks at the barriers to screening uptake and considers interventions, such as different ways of inviting people, to improve uptake.

ii. Since June 2020, screening uptake in minority ethnic groups has been discussed by the Wales Screening Committee. This has included reporting on actions taken by Public Health Wales to engage with low-uptake groups such as minority ethnic communities and work being undertaken with stakeholders to explore barriers to uptake with the general population and low uptake groups. Public Health Wales has presented its Screening Equity Strategy, Screening Division Inequities in Uptake Report

2020-21 and an update on equality, diversity and inclusion in screening to the Committee.

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

   i. Tackling inequality underpins the Welsh Government's health improvement strategies. For example, the Tobacco Control strategy acknowledges that COVID highlighted stark inequalities, including the disproportionately higher prevalence levels of tobacco in our more disadvantaged communities, our LGBTQIA+ and some minoritised communities. Our action plans supporting those strategies seek to tackle inequalities in all their forms.

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

   i. The Welsh Government communicated a clear message to patients that GP services remained open during the pandemic. The Welsh Government is committed to the approach of seeing the right person at the right time in the right place and the Primary Care Model for Wales. Access standards were revised for 22/23, with a requirement introduced for practices to evidence a review of population and access needs through use of a patient survey and an equality impact assessment of patient need. Practices are required to produce an annual report to the health board detailing the findings and proposed actions. The Welsh Government has also published guidance on the access standards and equality impact assessments.

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

   i. The Chief Medical Officer for Wales had an initial review of the evidence on the disproportionate effects of Covid-19 and the wider underpinning health inequalities affecting Black, Asian and Minority Ethnic communities that can drive this work. The Welsh Government is committed to developing this work and working with Black, Asian and Minority Ethnic groups to consider its findings and what may be done to drive service and health outcome improvements.

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

   i. The Welsh Government was already committed to reducing health inequalities and promoting equity of access to mental health services was a key underpinning action in the Together for Mental Health Delivery Plan 2019 to 2022. The revised plan includes the commitment for Health Boards to deliver more appropriate care and support through adoption of Diverse Cymru's Cultural Competency toolkit. The Welsh Government has worked with Diverse Cymru to accelerate this action and have provided Diverse Cymru with funding to continue to deliver their cultural competency scheme and training. The funding currently ends in March 2025.

   ii. The Together for Mental Health plan committed to improving data on mental health through the introduction of the Mental Health Core dataset. This included capturing information on ethnicity. The new

data set for s135 to 136 detentions developed by the Mental Health Crisis Concordat Assurance Group was implemented in April 2019 and includes data on ethnicity. The data is published on Stats Wales. The Together for Mental Health delivery plan was also revised in response to COVID-19, including ensuring closer alignment with the Race Equality Action Plan and actions to strengthen engagement with groups disproportionally impacted by COVID-19, to improve awareness and access to mental health services.

iii. The Welsh Government has continued to make available resources in multiple languages to support access to healthcare, for example, through translating resources such as the National Centre for Mental Health Toolkit for people who have been exposed to traumatic events, and materials to promote the CALL mental health helpline (into over 20 languages). CALL also uses Language Line – which means anyone calling the helpline can access support and advice in their preferred language.

iv. In May 2021, the Welsh Government established a task and finish group (chaired by the Wales Alliance for Mental Health) with the third sector and community organisations looking at ways to improve the access to and quality of support in mental health services for people from Black, Asian and Minority Ethnic communities. The task and finish group continues to be a key reference group in the development of the new Mental Health and Wellbeing Strategy and the Suicide and Self-harm Prevention Strategy for Wales. Improvement Cymru has also led on work to develop good practice guidelines to improve access to and quality of psychological interventions for people from Black, Asian and minority ethnic backgrounds.

165. Promoting cultural competency remains a key priority in the new Mental Health and Wellbeing Strategy for Wales (2024-2034). A new draft strategy was recently issued for consultation and will be supported by the Health Education and Improvement Wales and Social Care Wales Strategic Mental Health Workforce Plan,

which is described further below in the context of the Locked Out report recommendations.

166. Additionally, the Welsh Government continued to engage with established groups such as Disability Equality Forum; Race Equality Forum, Faith Communities Forum, the Third Sector Partnership Council, the Refugee and Asylum Seeker Taskforce. I was nor directly involved in these groups but many of them worked my colleague Jane Hutt MS, who at the time, held the Cabinet position of Deputy Minister and Chief Whip. A number of concerns and areas for consideration were discussed in those forums were fed back to me, and other Ministers, for example;

a) The provision of PPE for unpaid carers of people shielding;
b) The need for shielding groups to be represented as part of the 21-day review process, to ensure that the impact on those groups of the easing of restrictions was taken into account;
c) The need for clear face masks to assist those who relied on lip reading to communicate.

167. Jane Hutt also attended the Cross-Party Group on Disability. I have exhibited the minutes of a meeting of that group on 28 January 2021 at **M3VGE01/069 – INQ000492770** in which the issue of clear face masks was discussed. It was noted that clear face masks did not provide the same degree of protection as a three-layer face covering and so the Welsh Government did not recommend them for use by the general public or where social distancing of 2m could not be maintained. The Welsh Government encouraged people to temporarily lower their face covering whilst maintaining social distancing to communicate with someone who relied on lip reading or facial expressions. A number of transparent masks for NHS and social care staff were distributed and Public Health Wales took the lead in engaging with a trial of a "ClearMask" face covering which was run by the Department of Health and Social Care. The ClearMasks were distributed to all Health Boards in Wales and their use required a risk assessment to be carried out by the relevant NHS organisation in Wales.

168. The Deputy Chief Medical Officer wrote to all Health Boards and Trusts in Wales to raise awareness of the communication barriers for D/deaf people and people living with hearing loss. The Welsh Government also contacted NHS organisations in Wales requesting they engaged with their equality leads to ensure the principles of the All Wales Standards for Accessible Communication and Information for People with Sensory loss were being complied with.

169. In addition to those listed above, other reports and recommendations were published throughout the pandemic.

a) The 'Locked Out, Liberating disabled people's lives and rights in Wales beyond Covid-19' Report, commissioned by the Disability Equality Forum was published on 02 July 2021 which I exhibit at **M3VGE01/070 - INQ000227530**. This report made a number of recommendations relating to the healthcare system, set out below. As a result of this report, the Disability Rights Taskforce was established to bring together people with lived experience, Welsh Government policy leads and representative organisations to identify the issues and barriers that affect the lives of many disabled people.

That the Welsh Government immediately re-affirms its 2002 commitment to the Social Model of Disability.

i. The Welsh Government is committed to embedding the Social Model of Disability throughout everything it does. The work of the Disability Rights Taskforce is based on a common understanding of the Social Model of Disability, Human Rights, and co-production. All members of the taskforce and its working groups have been offered training on the Social Model of Disability. In conjunction with DAAS (the Welsh Government's disabled staff network) the taskforce team has provided Social Model of Disability training to Care Inspectorate Wales and Healthcare Inspectorate Wales and the Welsh Government's legal services.

ii. The Welsh Government's Disability Disparity Evidence Unit has commissioned research to develop and test survey questions that can be used to collect data to identify people with health conditions who experience societal barriers that disable them. This will support the Welsh Government to understand the impact of policies on disabled people and how policies can reduce or remove barriers for people with health conditions.

That the Welsh Government implements UN recommendations that nations fully involve disabled people in the planning stages of all future responses to public crises.

iii. The Welsh Government is fully committed to involving disabled people in our planning work for future crises, including pandemic planning. Standing Ministerial forums and groups of those with protected characteristics under the Equality Act 2010, such as the Disability Equality Forum, meet regularly. Fundamental to our work will be engaging with these forums and groups to understand the impact of decisions on those groups most likely to be impacted / disproportionately impacted.

The co-production of a Patient Charter for Wales that is produced with diverse groups and gives patients more rights and power.

iv. The Welsh Government does not currently have plans for a Patient Charter for Wales, but remains committed to the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act, enacted on 1 June 2020 and which came into force on 1 April 2023. The act aims to:

    1. strengthen the existing Duty of Quality on NHS bodies and extend it to the Welsh ministers for their health service functions.
    2. create a Duty of Candour on NHS service providers for openness and honesty with patients and service users harmed during care; and

3. amplify voices by replacing community health councils with Llais, an all-Wales citizen body for health and social care.

That the Welsh Government establishes priority criteria to ensure disabled people to receive timely diagnosis and medical evidence that are pre-requisites for accessing key areas of day-to-day living for example, benefits, shopping, work, reasonable adjustments, social support.

v. Existing Good Medical Practice guidance sets out that patients should be treated as individuals with specific needs and that all patients should receive good care and treatment that will support them to live well, whatever their illness or disability. Doctors are also expected to consider and respond to the needs of disabled patients.

That emergency changes made to the Mental Health Act be reviewed and reversed immediately in Wales and that in future the Welsh Government adopts a more nuanced patient-centred approach to the provision of mental health services, to establish a better dialogue about patient needs and preferences and mental health service delivery.

vi. The powers in question relating to the Mental Health Act were never used and expired in March 2022. The Mental Health (Wales) Measure 2010 ensures that people who require more specialised care and support have a Care Co-ordinator. This includes an assessment of a person's health and social care needs, and a plan to which considers eight areas of life – for instance finance, accommodations and work. Further actions to improve person centred care have been set out in the new Mental Health and Wellbeing Strategy, which was recently issued for public consultation. Consultation responses are currently being analysed and it is anticipated that a summary report will be published in October 2024. A revised strategy and supporting delivery plan and impact assessments will be published later this year.

That the Welsh Government invests in future research and recruits and trains more local people to work in mental health services in Wales,

including making it a focus of careers advice / workshops in educational settings and offering 'golden handcuffs' arrangements, with funded training packages available to those who commit to working in the field in Wales for x number of years.

vii. One of the fundamental building blocks of the new Mental Health and Wellbeing Strategy (2024-2034) is a sustainable mental health workforce. This will be achieved through the implementation of the Health Education and Improvement Wales and Social Care Wales Strategic Mental Health Workforce Plan. Published at the end of 2022, the Mental Health Workforce Plan sets out 33 actions across seven key themes, and aims to improve prevention and early intervention services, as well as addressing pressures on services for people with serious mental health needs. The plan is aligned to the 10-year Workforce Strategy for Health and Social Care in Wales. The actions set out in the Strategic Mental Health Workforce Plan are intended to deliver "a motivated, engaged and valued health and social care mental health workforce, with the capacity, competence and confidence to meet the needs of the people of Wales". An Implementation Plan has been developed for the 33 actions (published in May 2023) and will support the delivery of a skilled, supported and sustainable mental health workforce. Every action is underpinned by a focus on Welsh Language and equalities.

That it is ensured that the experiences of disabled/ diverse groups in Wales are incorporated and they are involved in setting objectives and monitoring outcomes and that the Welsh Government issues clear guidance to local authorities and health boards on best practice, including meaningful co-production; and

That the Welsh Government establishes a working group with DPOs to ensure that best practice guidance for local authorities and health boards/ services in Wales on public accessibility is a priority.

viii. The Disability Rights Taskforce works collaboratively with people with lived experience and expertise, disabled people's organisations, Welsh Government policy leads and other interested bodies/organisations. The Taskforce has held ten thematic working groups, these were:

- Embedding and Understanding of the Social Model of Disability
- Access to Services (including Communications and Technology)
- Independent Living: Health
- Independent Living: Social Care
- Employment and Income
- Travel
- Children and Young People
- Affordable and Accessible Housing
- Access to Justice
- Well-being (as a workshop)

Over 350 external group members – including disabled people and colleagues from disabled people's organisations – and over 200 government policy leads have worked to co-produce recommendations. All working groups have now concluded. The Taskforce will consider, from each working group, the key recommendations required to achieve improvements for disabled adults and children in Wales. An action plan is currently in development.

That the Welsh Government reviews the role of GPs and other medical professionals in the identification and categorisation of individuals at 'high risk' or 'shielding' groups.

ix. All available data was used to quickly identify those who were at high risk or should be in a shielding group. GPs and other medical professionals were able to add further people who in their clinical opinion should be included within those defined groups.

That the Welsh Government continually reviews and ensures that clear, accessible and consistent guidance about Covid-19 fully complies with equality and human rights laws and standards, including the principles of individual autonomy and non-discrimination as recommended by the EHRC.

x. Welsh Government guidance relating to Covid-19 is produced in accordance with the public sector equality duty and other applicable standards. Further information about the Welsh Government's implementation of the public sector equality duty during the pandemic is set out in the M3/WGO/02 witness statement at paragraphs 755 – 764.

That the Welsh Government introduces a mandatory training requirement into the Welsh NHS, which is co-developed and co-delivered with Welsh DPOs, to begin to address medical discrimination being experienced by disabled people during the pandemic.

xi. The introduction of training for the workforce on the social model of disability is a recommendation being taken forward by the Disability Rights Taskforce. As noted above, Healthcare Inspectorate Wales and Care Inspectorate Wales have already received bespoke training in the Social Model of Disability and will apply this knowledge to inspections of health and social care service.

A hybrid model of in-person appointments (with relevant PPE) and remote appointments, and that financial incentives to retain in-person provision are built into future health service planning.

xii. In-person appointments, where clinically necessary, were retained in primary care throughout the pandemic and we have since seen a return to a predominantly in-person appointment model. Where appropriate, remote appointments may be offered making use of digital technology to improve access to primary care services. Financial incentives to retain in-person provision of primary care services were not provided.

That health and well-being data is disaggregated by disabled status and other protected characteristics. In addition, further data is required on rates of Covid-19 infections in Wales, hospitalisations, effects on mental health and well-being: disaggregated by disability, sex, gender, age, race and income and across multiple 'high risk' groups.

xiii. In December 2023, the Equality, Race and Disability Evidence Units produced and published the statistical bulletin Disabled Peoples outcomes in health, housing, education and economic status (Census 2021). This output included analysis of the health outcomes of disabled people in Wales sourced from the 2021 Census.

xiv. The Welsh Government's Equality, Race and Disability Evidence Units are undertaking a detailed audit of equalities data across all topic areas. The purpose of this work stream is to examine what equality data and evidence on those with protected and associated characteristics is currently collected and analysed in Wales, with the intention of identifying data-gaps and recommending improvements to sources and statistical outputs. An initial review of the Welsh Government's Official Statistics outputs and the data sources underpinning them has been undertaken. Findings from this first phase of the audit will be published in Autumn 2024.

xv. Through work on the Mental Health Core Data Set, the Welsh Government is prioritising demographic data, such as age, gender and ethnicity which will support our ability to plan services based on the needs and demands of our population. As we transform services with new pathways of support, robust data monitoring and reporting is a key requirement. For instance, the 111 press 2 service for urgent mental health includes the collection of a comprehensive range of data which includes a pre and post assessment of distress levels and information about the outcomes for individuals who have been supported.

An assessment of the long-term effects on future generations of inadequate and inaccessible maternity services during the pandemic.

xvi. Accessibility to maternity services during the pandemic was informed by published visiting guidance which was regularly reviewed and informed by the visiting guidance working group representing all health boards. In a Written Statement in May 22, the Minister for Health and Social services emphasised the requirement to consider each individual case and stated that:

xvii. 'The health, safety and wellbeing of pregnant women, birthing people and their babies and the staff in maternity and neonatal units and in the community is crucial and remains our absolute priority. I continue to expect all requests for visiting in healthcare settings to be treated with compassion and empathy whilst ensuring the patient's best interests are met and local risk assessment processes are followed.

xviii. The guidance being published today continues to categorise a nominated partner supporting a woman during hospital visits as an essential visitor. Equally parents/primary care givers are partners in neonatal care, and as such should never be considered as visitors to neonatal units and must also be considered essential to their baby's health and wellbeing.

xix. The guidance spells out the key principles we can expect to be followed in every health board in Wales to ensure pregnant mothers and babies receive an equity of experience wherever they receive their care.'

xx. Since the removal of legal restrictions and measures health boards and trusts have been implementing their own hospital visiting policies to reflect local coronavirus rates.

That women be allowed to self-register their requirements and that requests for reasonable adjustments are properly formalised to allow for

proper consideration of whether a partner / advocate is needed at maternity appointments, and that a system of self-registration be implemented for those 'shielding' in Wales and for women using maternity services.

xxi. The Shielding Patient List ended on 31 March 2022 and so from 1 April 2022, those who are identified as Clinically Extremely Vulnerable should follow the same advice as everyone else unless they have received specific advice from their GP or Health Clinician. Self-registration was not implemented for the Shielded Patient List prior to its conclusion.

b) A strengthening and advancing equality and human rights in Wales Research report was published on 26 August 2021 which I exhibit as **M3VGE01/071 - INQ000282171.** The report made broad cross-government recommendations aimed at promoting and giving effect to human rights. It did not include any specific recommendations relating to the healthcare system.

c) A summary report on the First Minister's Black, Asian, Minority Ethnic Covid -19 Advisory Group was published in September 2021 which I exhibit as **M3VGE01/072 - INQ000066078.** This report described the creation and work of the socio-economic subgroup and risk assessment subgroup, as set out in paragraphs 428 to 438 of M3-WGO-02.

170. The Covid 19 Moral and Ethical Advisory Group Wales ("CMEAG") was established to gather and co-ordinate issues relating to moral, ethical, cultural and faith considerations, and provide a source of advice to public services on issues arising from the health and social care emergency response to the Covid-19 pandemic. Paragraph 127 of M3-WGO-01 provides details on the considerations noted in the framework with regards to good decision making and the clinical ethical support for healthcare decision making. The framework refers to the need to promote equity by assessing and responding to individual need, avoiding blanket policies based on protected characteristics especially disability or age.

171. On 19 October 2020, the Welsh Government's Technical Advisory Cell published a Coronavirus (Covid-19) and Health inequalities report which I exhibit at **M3VGE01/073 - INQ000066285**. The report focused on health inequalities by socioeconomic position and was intended to complement the report of the Black, Asian and Minority Ethnic Advisory Group.

172. Wales has a larger percentage of the population aged 65 years or older than the rest of the UK. Guidance for providers working with older people, and those in receipt of care, was drafted in conjunction with Care Inspectorate Wales, Care Forum Wales and the Older People's Commissioner. We set out to ensure that the rights of older people continuously informed and influenced our evidence gathering, analysis and decision making through a range of bespoke arrangements.

173. Additionally, there was engagement, although not exclusively, through the Social Care Planning and Response Sub-group, the Ministerial Advisory Forum on Ageing and the regular meetings with Ministers and senior officials. Existing mechanisms such as the Disability and Race Equality Forums chaired by the Deputy Minister and Chief Whip also played a significant role in balancing our responsibilities.

Equality and Local Government Committee

174. On 3 August 2020, I exhibit a joint letter the Deputy Minster and Chief Whip and I sent to the Equality and Local Government Committee in response to their request for further evidence from the Welsh Government at **M3VGE01/074 - INQ000299537**.

175. On 10 August 2020, the Equality, Local Government and Communities Committee of the Senedd published its report on inequality during the pandemic, entitled "Into Sharp Relief: Inequality and the Pandemic" which I exhibit at **M3VGE01/075 - INQ000353436**. The Welsh Government responded to this report on 23 September 2020, by way of a joint letter from myself, the Minister for Education, the Minister for Housing and Local Government and the Deputy Minister and Chief Whip. We agreed to take forward forty two of the forty-four Committee's recommendations which I exhibit at **M3VGE01/076 - INQ000066490**.

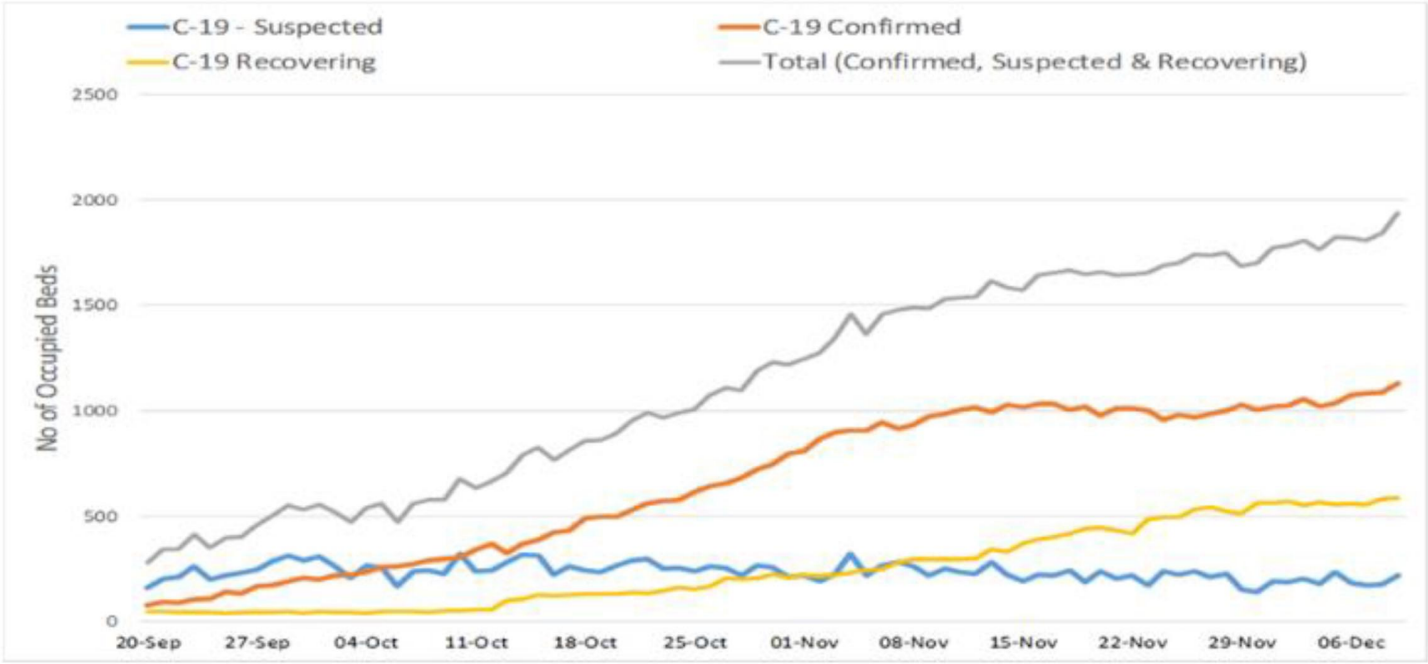
Data and statistics available to me

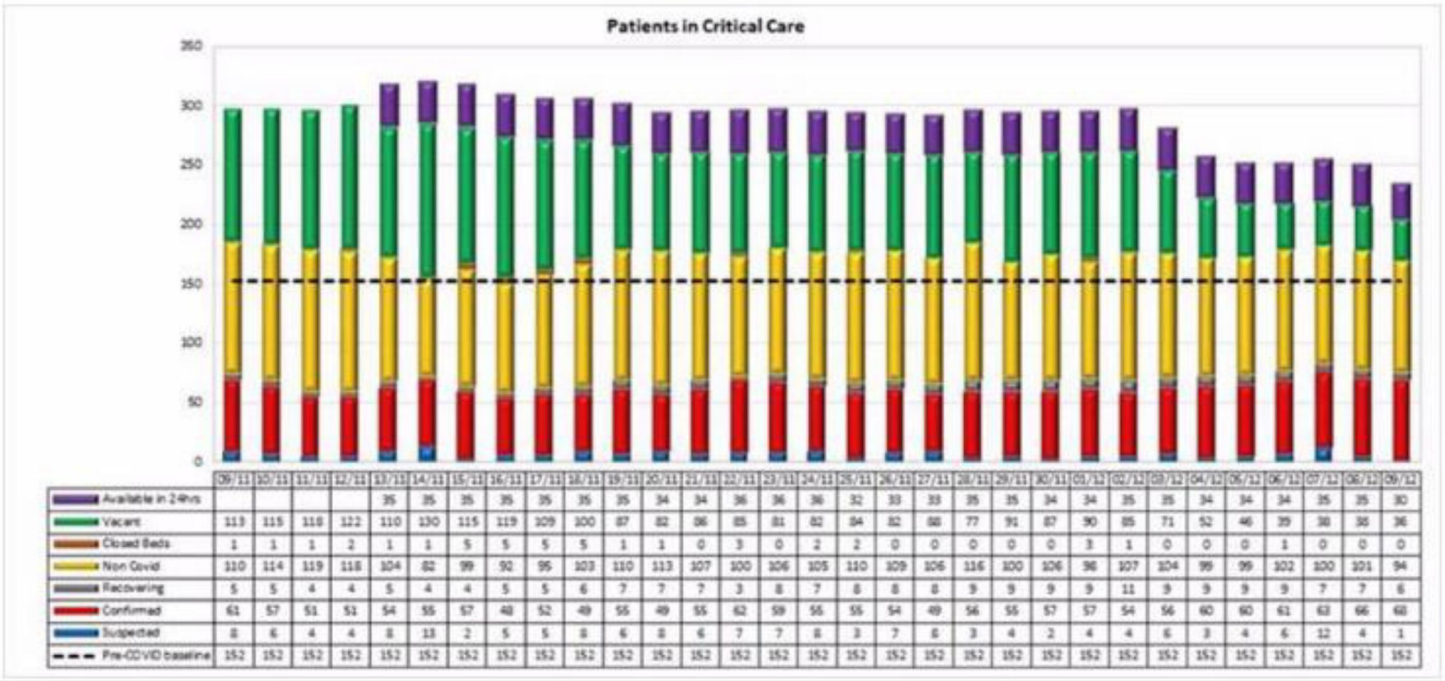
176. I received a daily 'NHS update' from Andrew Goodall which presented key data including bed and critical care capacity and occupancy, broken down by Covid-19 status (suspected, confirmed, recovering and non-Covid-19), along with comparisons with previous days and weeks. The update also included Andrew Goodall's written comments on and assessment of the data. I understand that Andrew Goodall produced the NHS update from the Welsh Government daily sitrep spreadsheets, which are described in paragraphs 158-160 of M3-WGO-02.

177. By way of example, the figures below are screenshots from the daily NHS update I received from Dr Goodall on 9 December 2020, as exhibited in **M3VGE01/077 - INQ000361644**. I would discuss the data I received with Dr Goodall and other Welsh Government officials, and would ask for more information where necessary, though I do not recall asking for new categories of data to be added to the regular updates I received.

		Critical Care (CC) Beds			Total Beds		
		Current Day	Previous Day		Current Day	Previous Day	
		09-Dec-20	08-Dec-20	Difference	09-Dec-20	08-Dec-20	Difference
Number of available staffed beds	In critical care environment	161	172	-11			
	Outside critical care environment	18	18	0			
	Specialist critical care environment	26	26	0			
Number of closed beds		-	-	0			
Total number of critical care beds		**205**	**216**	**-11**			
Number of COVID-19 patients in occupied beds	Suspected	1	4	**-3**	220	175	45
	Confirmed	68	66	**2**	1,131	1,085	46
	Recovering	6	7	**-1**	585	578	7
Total number of COVID-19 occupied beds		**75**	**77**	**-2**	**1,936**	**1,838**	**98**
Number of non COVID-19 occupied beds		94	101	- 7	6,073	6,060	13
% critical care beds occupied		82%	82%	0%			
% critical care beds occupied COVID-19 related patients		37%	36%	1%			
Number of unoccupied critical care beds		36	38	-2			

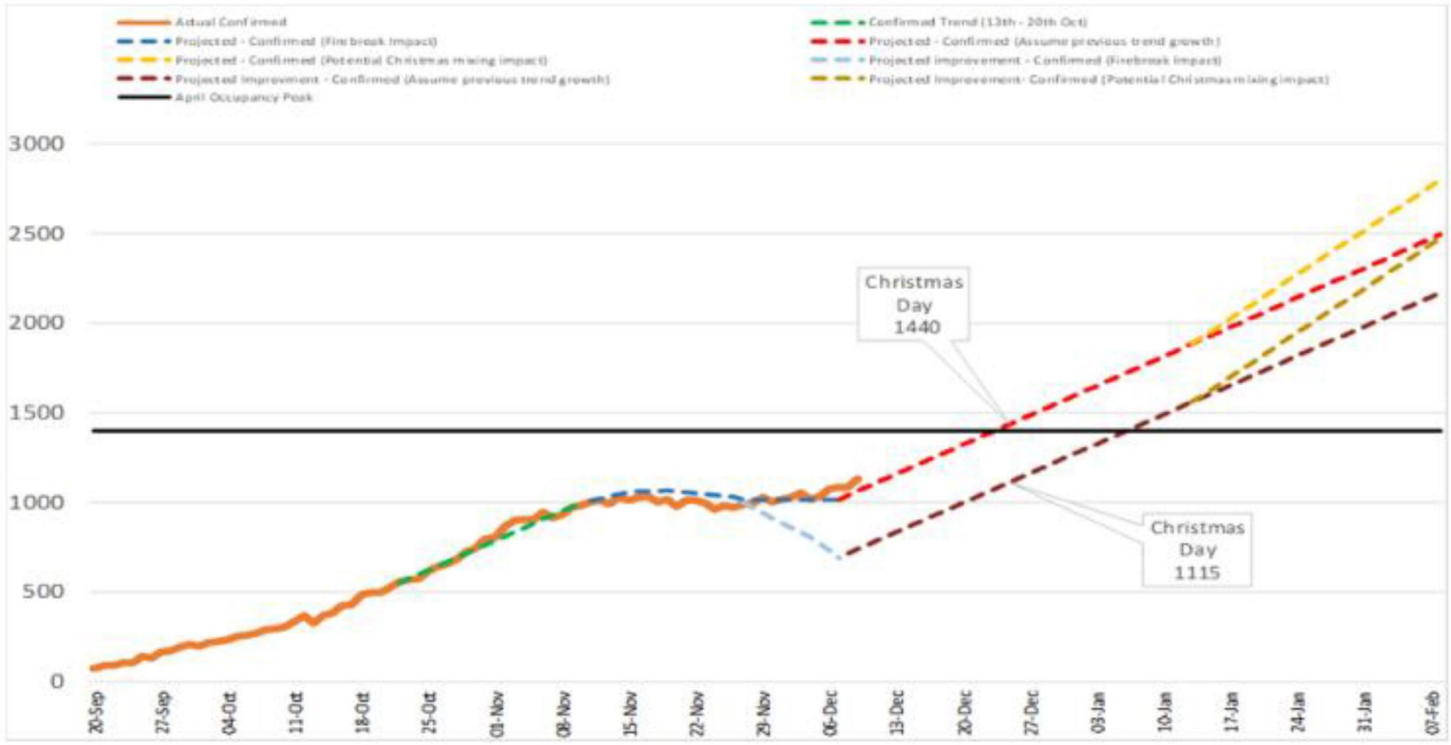
	Number of COVID-19 patients in occupied beds	
	Critical care (CC) Beds	Total Beds
Current Day	75	1,936
Same Day Prev Week	69	1,783
Difference	**6 (9%)**	**153 (9%)**
Current Day	75	1,936
Highest Prev Day	164	1,936
Difference	**-89 (-54%)**	**0 (0%)**





	09/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	01/12	02/12	03/12	04/12	05/12	06/12	07/12	08/12	09/12
Available in 24hrs					35	35	35	35	35	35	35	34	34	36	36	36	32	33	33	35	35	34	34	35	35	34	34	34	35	35	30
Vacant	113	115	118	122	110	130	115	119	109	100	87	82	86	85	81	82	84	82	88	77	91	87	90	85	71	52	46	39	38	38	36
Closed Beds	1	1	1	2	1	1	5	5	5	5	1	1	0	3	0	2	2	0	0	0	0	0	3	1	0	0	0	1	0	0	0
Non Covid	110	114	119	118	104	82	99	92	95	103	110	113	107	100	106	105	110	109	106	116	100	106	98	107	104	99	99	102	100	101	94
Recovering	5	5	4	4	5	4	4	5	5	6	7	7	7	3	8	7	8	8	8	9	9	9	9	11	9	9	9	9	7	7	6
Confirmed	61	57	51	51	54	55	57	48	52	49	55	49	55	62	59	55	55	54	49	56	55	57	57	54	56	60	60	61	63	66	68
Suspected	8	6	4	4	8	11	2	5	5	8	6	8	6	7	7	8	3	7	8	3	4	2	4	4	6	3	4	6	12	4	1
Pre-COVID baseline	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152	152

Note graph below tracks “confirmed” rather than total covid-related patients in hospital beds:



178. I also received a 'daily figures' email which included data on the number of positive cases broken down by local authority and by key groups, deaths and testing figures. The screenshots below are an example from the daily figures email on 28 April 2021, which are exhibited in **M3VGE01/078 - INQ000479974**.

1. Headline figures for Wales

Nation: Wales		
Case data as at: 9am (09:00) 28-04-2021 Death data as at: 9am (09:00) 28-04-2021		
	Newly reported since last report	Total cumulative
Positive cases	69	211,458
Deaths	2	5,550

2. Data from Wales with lighthouse laboratories data included

Nation: Wales	
Data as at 9am (09:00) 28-04-2021	
Covid-19	Results at 9am
PHW Lab capacity	15,167*
Total number of negative cases to date	1,729,974
Total number of positive cases to date	211,458
Total number of individuals tested	1,941,432
Total number of tests completed since last report	12,829
New positive cases since last report	69
Total number of tests cumulative	3,310,501
Yesterday's cumulative tests	3,292,161

*** Maximum capacity of the equipment and kits**

3. Data for NHS Wales and Lighthouse labs separated

	New cases	Cumulative cases	New tests	Cumulative tests
NHS Wales labs	13	58,295	4,191	1,208,851
Lighthouse labs	56	153,163	8,638	2,101,650
Total	69	211,458	12,829	3,310,501

Data are provisional and may change daily

4. **New cases reported by Local Authority as at 9am 28/04/2021.**

Local Authority	New cases	Cumulative cases	Cumulative Incidence per 100,000
Blaenau Gwent	0	6,164	8,823.1
Caerphilly	6	13,430	7,416.8
Monmouthshire	2	4,178	4,417.0
Newport	11	11,311	7,312.7
Torfaen	1	6,436	6,849.7
Conwy	1	3,870	3,302.0
Denbighshire	0	4,331	4,525.8
Flintshire	1	9,613	6,158.2
Gwynedd	4	3,395	2,725.6
Isle of Anglesey	2	2,301	3,285.1
Wrexham	4	11,477	8,441.6
Cardiff	9	26,159	7,129.7
Vale of Glamorgan	1	7,441	5,570.2
Bridgend	2	12,589	8,561.1
Merthyr Tydfil	2	6,728	11,152.7
Rhondda Cynon Taf	3	21,337	8,843.8
Carmarthenshire	7	10,766	5,703.2
Ceredigion	0	1,772	2,437.6
Pembrokeshire	0	3,456	2,746.8
Neath Port Talbot	2	11,635	8,118.5
Swansea	8	17,576	7,116.0
Powys	3	4,177	3,154.0
Outside Wales	0	9,406	
Unknown	0	1,910	
Wales Total	**69**	**202,052**	6,408.5
Total	**69**	**211,458**	

Due to daily data cleaning there may be some movement in cumulative cases for each local authority.

5. **Breakdown of COVID-19 cases in Wales by Local Authority, as at 9am 28/04/2021.**
7-day incidence period reported: 18/04/2021 to 24/04/2021

For the 7 day period ending at 23:59 on 24-04-2021	All Confirmed Episodes								
	n	% of All Wales Total (location known)	7-day incidence	Incidence threshold reached	Change from previous week	Test positivity	Positivity threshold reached	Change from previous week	Testing Incidence per 100,000
Blaenau Gwent	6	1.6%	8.6	Under 15	7.2 ↑	0.8%	Under 2.5%	0.7% ↑	1030.6
Caerphilly	15	4.0%	8.3	Under 15	0.6 ↑	0.9%	Under 2.5%	0.0% ↑	902.4
Monmouthshire	5	1.3%	5.3	Under 15	1.1 ↑	0.6%	Under 2.5%	0.1% ↑	820.4
Newport	47	12.6%	30.4	25 to <50	3.9 ↑	2.9%	2.5 to <5%	0.3% ↑	1044.8
Torfaen	7	1.9%	7.4	Under 15	-10.6 ↓	0.7%	Under 2.5%	-1.3% ↓	1016.4
Aneurin Bevan	80	21.4%	13.5	Under 15	0.5 ↑	1.4%	Under 2.5%	0.0% ↓	961.9
Conwy	7	1.9%	6.0	Under 15	0.0 →	0.6%	Under 2.5%	0.0% ↓	940.2
Denbighshire	4	1.1%	4.2	Under 15	-4.2 ↓	0.5%	Under 2.5%	-0.4% ↓	921.7
Flintshire	16	4.3%	10.2	Under 15	-5.8 ↓	1.5%	Under 2.5%	-0.6% ↓	703.4
Gwynedd	23	6.1%	18.5	15 to <20	-10.4 ↓	2.1%	Under 2.5%	-1.4% ↓	891.9
Isle of Anglesey	5	1.3%	7.1	Under 15	-4.3 ↓	0.9%	Under 2.5%	-0.5% ↓	776.7
Wrexham	29	7.8%	21.3	20 to <25	7.4 ↑	2.4%	Under 2.5%	1.2% ↑	881.2
Betsi Cadwaladr	84	22.5%	12.0	Under 15	-2.7 ↓	1.4%	Under 2.5%	-0.2% ↓	848.4
Cardiff	43	11.5%	11.7	Under 15	-9.8 ↓	1.5%	Under 2.5%	-1.1% ↓	885.5
Vale of Glamorgan	11	2.9%	8.2	Under 15	-1.5 ↓	0.9%	Under 2.5%	-0.3% ↓	903.5
Cardiff and Vale	54	14.4%	10.8	Under 15	-7.6 ↓	1.2%	Under 2.5%	-0.9% ↓	890.3
Bridgend	16	4.3%	10.9	Under 15	2.7 ↑	1.1%	Under 2.5%	0.2% ↑	894.2
Merthyr Tydfil	3	0.8%	5.0	Under 15	-5.0 ↓	0.6%	Under 2.5%	-0.5% ↓	794.0
Rhondda Cynon Taf	15	4.0%	6.2	Under 15	-7.9 ↓	0.7%	Under 2.5%	-0.9% ↓	846.4
Cwm Taf Morgannwg	34	9.1%	7.6	Under 15	-4.0 ↓	0.9%	Under 2.5%	-0.5% ↓	887.8
Carmarthenshire	20	5.3%	10.6	Under 15	4.2 ↑	1.3%	Under 2.5%	0.6% ↑	823.2
Ceredigion	4	1.1%	5.5	Under 15	-1.4 ↓	0.8%	Under 2.5%	-0.2% ↓	722.2
Pembrokeshire	7	1.9%	5.6	Under 15	2.4 ↑	0.8%	Under 2.5%	0.4% ↑	737.6
Hywel Dda	31	8.3%	8.0	Under 15	2.6 ↑	1.0%	Under 2.5%	0.4% ↑	776.4
Powys	14	3.7%	10.6	Under 15	-6.0 ↓	1.6%	Under 2.5%	-0.9% ↓	648.6
Powys	14	3.7%	10.6	Under 15	-6.0 ↓	1.6%	Under 2.5%	-0.9% ↓	648.6
Neath Port Talbot	24	6.4%	16.7	15 to <20	-2.1 ↓	1.8%	Under 2.5%	0.0% ↓	916.9
Swansea	53	14.2%	21.5	20 to <25	-4.5 ↓	2.3%	Under 2.5%	-0.5% ↓	940.1
Swansea Bay	77	20.6%	19.7	15 to <20	-3.6 ↓	2.1%	Under 2.5%	-0.3% ↓	931.6
Total	374	100.0%	11.9	Under 15	-2.7 ↓	1.4%	Under 2.5%	-0.3% ↓	875.1
Unknown	4			N/A			N/A		
Total (including location unknown)	378	N/A	12.0	Under 15	-2.7 ↓	1.4%	Under 2.5%	-0.3% ↓	886.1

6. **Breakdown of COVID-19 cases in Wales by Local Authority and Age, as at 9am 28/04/2021.**
7-day incidence period reported: 18/04/2021 to 24/04/2021

For the 7 day period ending at 23:59 on 24-04-2021	Aged 25 and under					Aged 60 and over				
	n	7-day incidence	Change from previous week	Test positivity	Testing Incidence per 100,000	n	7-day incidence	Change from previous week	Test positivity	Testing Incidence per 100,000
Blaenau Gwent	3	15.1	10.1 ↑	1.6%	936.4	0	0.0	0.0 →	0.0%	989.5
Caerphilly	6	11.1	3.7 ↑	1.4%	791.4	1	2.2	-8.6 ↓	0.2%	879.5
Monmouthshire	1	4.1	4.1 ↑	0.6%	639.0	2	6.6	0.0 →	0.9%	747.1
Newport	17	34.6	0.0 →	3.5%	976.4	7	20.0	5.7 ↑	2.3%	859.1
Torfaen	2	7.2	-17.9 ↓	0.9%	830.5	2	8.0	0.0 →	0.8%	1004.5
Aneurin Bevan	29	16.6	0.0 →	2.0%	844.8	12	7.7	-1.3 ↓	0.9%	882.2
Conwy	2	6.8	-3.4 ↓	0.9%	749.2	3	7.3	0.0 →	0.8%	914.0
Denbighshire	3	11.2	-3.7 ↓	1.7%	653.9	0	0.0	-6.8 ↓	0.0%	896.1
Flintshire	5	11.1	-6.7 ↓	1.8%	631.9	2	4.7	-2.4 ↓	0.7%	710.6
Gwynedd	7	18.0	-10.3 ↓	2.9%	612.5	5	13.8	-5.5 ↓	1.5%	899.1
Isle of Anglesey	0	0.0	-16.3 ↓	0.0%	753.4	4	17.1	-4.3 ↓	2.2%	778.7
Wrexham	3	7.5	-10.0 ↓	1.0%	717.3	9	25.3	22.5 ↑	2.5%	996.6
Betsi Cadwaladr	20	10.1	-8.1 ↓	1.5%	677.0	23	11.1	1.0 ↑	1.3%	866.2
Cardiff	18	13.2	-6.6 ↓	1.5%	867.5	8	11.5	-2.9 ↓	1.4%	816.8
Vale of Glamorgan	3	7.8	0.0 →	0.9%	866.9	2	5.4	-2.7 ↓	0.6%	923.7
Cardiff and Vale	21	12.0	-5.1 ↓	1.4%	867.4	10	9.4	-2.8 ↓	1.1%	853.8
Bridgend	5	11.7	4.7 ↑	1.4%	835.0	3	7.7	-5.2 ↓	0.7%	1141.7
Merthyr Tydfil	1	5.4	5.4 ↑	0.9%	636.8	1	6.7	6.7 ↑	0.7%	974.9
RhonddaCynon Taf	1	1.4	-17.6 ↓	0.2%	691.9	3	5.0	-11.6 ↓	0.5%	1068.0
Cwm Taf Morgannwg	7	5.2	-7.4 ↓	0.7%	729.6	7	6.1	-7.0 ↓	0.6%	1080.8
Carmarthenshire	2	3.8	-3.8 ↓	0.6%	619.4	13	22.4	15.5 ↑	2.5%	895.4
Ceredigion	0	0.0	-8.8 ↓	0.0%	559.9	3	12.7	8.5 ↑	1.7%	751.4
Pembrokeshire	0	0.0	0.0 →	0.0%	607.8	1	2.4	0.0 →	0.3%	704.2
Hywel Dda	2	1.8	-3.7 ↓	0.3%	603.4	17	13.8	8.9 ↑	1.7%	803.3
Powys	2	6.0	-6.0 ↓	1.0%	582.0	8	17.3	-4.3 ↓	2.7%	644.9
Powys	2	6.0	-6.0 ↓	1.0%	582.0	8	17.3	-4.3 ↓	2.7%	644.9
Neath Port Talbot	10	24.4	0.0 →	2.6%	922.0	4	10.2	-12.7 ↓	1.2%	849.1
Swansea	23	28.8	0.0 →	3.3%	876.2	10	16.0	-9.6 ↓	1.8%	886.9
Swansea Bay	33	27.3	0.0 →	3.1%	891.8	14	13.7	-10.8 ↓	1.6%	872.4
Total	114	12.0	-4.3 ↓	1.6%	766.3	91	10.6	-1.5 ↓	1.2%	875.9

179. I also received Chief Medical Officer Incident and Outbreak updates which contained information on cases in hospitals from 24 June 2020 until 18 September 2020. This included numbers of cases per 100k, with weekly comparisons and other related incident and outbreak information. An example from 15 September 2020 is exhibited in **M3VGE01/079 - INQ000479959**. I wanted to be informed about such outbreaks and would ask for daily updates. This transitioned to daily emails to Ministers, providing us with data per region.

180. I have been asked to provide further details of the instance of under-reporting Covid-19 deaths by two Local Health Boards in April 2020, to which I referred in my Module 2B statement to the Inquiry.

181. On 23 April 2020, Betsi Cadwaladr University Health Board reported 110 deaths, of which 84 were retrospective, having occurred between 2 March and 22 April 2020. The retrospective reporting was as a result of a breakdown in communication between the Health Board and Public Health Wales, which was quickly addressed. Also in April 2020, Cwm Taf Morgannwg University Health Board carried out a local validation of Covid-19 death reports which identified that, of the 64 deaths reported between 19 March 2020 and 7 April 2020, there were 25 Covid-19 positive deaths to report and three which had previously been reported as Covid-19 positive but had been found not to have a positive test result. A process was put in place between the Health Board and Public Health Wales to validate data prior to reporting, and in both cases the reconciled numbers were published by Public Health Wales immediately.

182. On 28 April 2020, I made a Written Statement, exhibited in **M3VGE01/080 - INQ000262351**[3], stating that, following the identification on 23 April 2020 of a significant number of deaths that had not been reported to Public Health Wales, Welsh Government officials and Public Heath Wales had sought assurances from Health Boards and Trusts concerning the robustness of the reporting process. Published with the Written Statement was a review of the mechanism for reporting Covid-19 deaths

[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 [INQ000227103].

in Wales, which is exhibited in **M3VGE01/081 - INQ000395663**. The review confirmed a number of Welsh Government actions, including that the Chief Statistician would carry out a whole-system oversight role of reporting protocols, and the introduction of weekly calls between Welsh Government officials, Local Health Board leads and Public Health Wales to discuss incoming figures and identify any process issues. Following these actions I am not aware of any further issues with the accuracy of reporting the number of deaths, nor with the reliability or accuracy of any other data provided by the NHS in Wales.

Capacity

183. Dr Goodall provided me with regular updates on the status of the healthcare system and the response to Covid-19, as well as non-Covid-19 matters and our ability to maintain levels of care for non-Covid-19 conditions. I was also kept informed through regular meetings and updates from the Health and Social Services Group directors. While the Chief Medical Officer (Wales) was a key source of information during the pandemic, he focused more on clinical matters. With regards to the operational side of the healthcare system, which I understand to be the focus of Module 3 of the Inquiry, Andrew Goodall was my principal source of information. As I have described earlier in this statement, in addition to our regular meetings, I also received the daily NHS update from Andrew Goodall which gave me a snapshot of key data points, which were a significant part of my understanding of how the NHS was coping during the pandemic. I exhibit an example of the types of emails I received regularly from Andrew Goodall which were designed to ensure I understood the NHS position at **M3VGE01/082 – INQ000492757**.

184. Understanding the views of frontline workers and the position 'on the ground' was an important part of our response to Covid-19. Due to the nature of the pandemic, I was regrettably unable to visit hospitals to speak to healthcare staff as I would otherwise have done regularly. I sought the views of those working on the front line through regular meetings with the British Medical Association, the Royal College of Nursing, the medical Royal Colleges and trade union representatives.

185. As described in paragraphs 289-290 of M3-CNO-01 Jean White also kept me informed of pressures on NHS workers.

186. Health Board quarterly plans were reviewed as regards the segregation of Covid-19 and non-Covid-19 patient flows and the changes to capacity and flow rate occurring as a consequence of enhanced Infection Prevention and Control measures. The meetings I had with Chief Executives of NHS bodies provided another avenue to receive the views and feedback of their staff.

187. On 20 March 2020, I approved the early handover to Aneurin Bevan University Health Board of parts of the new Grange University Hospital. This was anticipated to provide up to 350 additional beds to support lower acuity patients by the end of April 2020. A copy of the Ministerial Advice is exhibited in **M3VGE01/083 - INQ000144857**.

188. Following a 24 March 2020 Ministerial Advice, exhibited in **M3VGE01/084 - INQ000361815**, I approved funding for the construction of a High Consequence Infectious Diseases facility at the University Hospital of Wales, Cardiff, initially as part of our overall response to Covid-19 but also to improve the resilience of the NHS in Wales and increase our future dedicated capacity for acute infectious diseases.

189. As is referred to in paragraph 605 of Andrew Goodall's statement, on 27 March 2020 I approved funding to support the deployment of nurse, midwife, medical, paramedical, Allied Health Professionals and healthcare scientist students. Funding was also provided to cover the costs of re-employing former staff who had recently left or retired. A copy of the Ministerial Advice I received is exhibited in **M3VGE01/085 - INQ000226982**.

190. On 23 April 2020 I approved a proposal for £10m to be allocated to support the system to enhance delivery of timely discharge of patients from acute and community hospitals to community settings including their home. This included the accelerated scaling up of rapid discharge schemes, and the opening of additional community capacity. The Ministerial Advice I received is exhibited in **M3VGE01/086 - INQ000215311**.

191. Following a Ministerial Advice dated 4 September 2020, exhibited in **M3VGE01/087 - INQ000235914**, I approved funding for Cardiff and Vale University Health Board to increase surge capacity by establishing a 400 bedded facility on the University Hospital of Wales site.

192. I have described efforts to increase capacity through the use of field hospitals and the independent healthcare sector later in this statement.

193. As set out in greater detail in paragraphs 452 to 458 of M3-WGO-01, at no point during the pandemic were bed capacity limits breached in Wales. The highest overall occupancy rate during my tenure as Minister for Health and Social Services was 86%, during September 2020. This included critical care, acute level, field hospitals, private hospitals and community hospital beds but additional surge capacity remained available if required.

194. Reporting on the capacity limits is carried out at a national level, rather than at individual hospitals or Local Health Boards. Therefore, I did not receive the daily information described in this statement relating to capacity at that level.

195. There were, however, significant pressures across Wales in the latter part of 2020. For example:

a) On 18 October 2020, Cabinet was informed, in the context of discussion regarding the need for a firebreak, that without intervention, the continued increase of cases of Covid-19 in Wales, in hospitals and in Intensive Care Units, would be too high for the NHS to sustain, and there was now a significant on-flow of patients into critical care beds. The Cabinet meeting minutes are exhibited in **M3VGE01/088 - INQ000022500**.

b) On 9 December 2020, I received a letter from the Chairs of two of the Local Health Boards letting me know that they had concerns that the health system could be overwhelmed. This letter is exhibited in **M3VGE01/089 - INQ000479968**. On the same day I received an email from Andrew Goodall, which stated that there was a visible increase in overall and confirmed cases and that cases were running ahead of the number that he

had shared with Cabinet as his personal worst-case scenario. The email from Dr Goodall is exhibited previously at **M3VGE01/077 - INQ000361644**.

196. With regards to difficulties with capacity at a more local level, M3-WGO-02 notes at paragraph 266 that capacity was significantly stretched across South Wales during periods in the pandemic, notably in December 2020 and January 2021 during which time Local Health Boards regularly reported CRITCON statuses of level 3, while in December 2020, Prince Charles Hospital, Cwm Taf Morgannwg, was close to declaring CRITCON 4 as all capacity had been exhausted there, but there was still limited capacity in neighbouring Local Health Boards.

197. CRITCON levels refer to the system of capacity status levels from 0 – 4 (4 being the most serious) which Local Health Boards could escalate to, facilitating greater levels mutual aid between neighbouring Health Boards. The CRITCON system and the mutual aid process are described in detail in paragraphs 259 to 266 of M3-WGO-02. The Welsh Government was not made aware of any incidents where a patient who was clinically appropriate to receive critical care was unable to access a critical care bed within the Local Health Board or from a neighbouring Local Health Board.

198. On 5 April 2020 I issued a Written Statement exhibited in **M3VGE01/090 - INQ000182395** addressing critical care capacity and ventilation. I expressed my thanks to my NHS colleagues and to all staff who retrained and who were redeployed to work in critical care settings. I advised in Wales the number of critical care beds was normally around 153 but as of 3 April 2020 there were 353 critical care beds and all of these were invasively ventilated. I was informed that the number was increasing on a daily basis. At that time occupancy was around 48% with just over half the beds occupied with patients with Covid-19. On this date there were also 173 CPAP beds (designated Covid-19) and a further 143 beds providing non-invasive ventilation (designated Covid-19)

199. In relation to ventilators, there were 415 ventilators in hospitals in Wales which could provide invasive ventilation. There were an additional 349 anesthetic machines with ventilator capacity and 207 non-invasive ventilators. A further 1,035 ventilators (made up of invasive and non-invasive) were also being procured by the NHS Wales

Shared Services Partnership and UK wide arrangements (made up of both invasive and non-invasive ventilators). Wales was to receive a population-based share of UK procurement. In Wales we had already received 100 dual purpose machines and were expecting a further 75 (made up of both invasive and non-invasive ventilators)

200. The means and rationale for selecting the figure of 1,035 ventilators is explained by Judith Paget in M3-WGO-02. In short it followed an assessment in March 2020 by the Acute Secondary Care Planning and Response Sub-group of oxygen devices available and in use. This included beds with piped oxygen, oxygen concentrators, oxygen cylinders, and non-invasive ventilation or CPAP devices. There was no target for the number of devices required and the expected figures were based on the number of devices thought to be available for procurement activity at that time.

201. On 15 April 2020 my office received the latest statistics covering a number of issues, including critical care capacity which I exhibit at **M3VGE01/091 - INQ000479934**. The stats revealed that around 46% of critical care capacity was unoccupied and available. But we were seeing more pressure on critical care beds in the South West of Wales.

202. On 20 April 2020 I received further confirmation, which I exhibit at **M3VGE01/092 - INQ000215284** that the critical care bed capacity was at 399 invasively ventilated beds with a further 88 available in within 24 hours, an additional 68 within seven days, and a further 227 beds following those seven days. 44% of invasive ventilation beds were occupied, with only 18% of invasive ventilators being used as of 28 April 2020. I was informed that the NHS in Wales had sufficient ventilators to meet current demands and at no point did we have insufficient capacity. Based on the occupancy levels, the predicted demand and current procurement process for ventilators, I was advised in exhibit **M3VGE01/093 - INQ000479937** there were no plans to procure any further ventilators at that time.

203. On 29 April 2020 I issued a Written Statement. in which I explained the latest figures for the procurement of invasive and non-invasive ventilators by the NHS Wales Shared Services Partnership via UK arrangements. At that time, I advised that occupancy levels of critical care beds were, at 43%, however it was important to

recognise that the number of invasively ventilated beds being used was significantly above normal critical care bed numbers in Wales. At the time of that statement the number of invasively ventilated or critical care beds stood at 286. CPAP machines were counted as part of the daily bed capacity SitRep reports and on 29 April 2020 there were a total of 1845 machines with 22 in use, 179 unavailable and 1644 available but not in use. I exhibit that Written Statement as **M3VGE01/094 - INQ000227110**.

204. I exhibit at **M3VGE01/095 - INQ000479941** a readout following the Healthcare Ministerial Implementation Group (MIG) on 7 May 2020 which described critical care capacity as "good".

205. On 31 October 2020, as part of a daily update, I was advised by Andrew Goodall that 40% of critical care capacity was used for Covid-19 patients but that was still well below the critical care occupancy recorded in April 2020. He confirmed the expansion plans of up to 292 beds were retained, with more if needed. I exhibit this email as **M3VGE01/096 – INQ000492754**.

206. As of 3 November 2020, the occupancy of critical care was 56%. 18% of critical care beds were occupied by Covid-19 related patients. There were 293 beds available across critical care beds in a critical care environment, specialist critical beds and critical care beds outside of a normal critical care environment, which covered those beds in theatre recovery for example. Health Boards had plans in place for a further 164 beds if required. I was advised that at the peak in April, there were 164 patients in critical care and therefore we were 67% below that peak exhibited at **M3VGE01/097 - INQ000479966**.

207. Following receipt of the internal and public Technical Advisory Cell summaries on 4 November I suggested a change to the way we presented critical care capacity. I suggested we reflect a percentage of occupancy figures against our usual baseline as I considered it presented a more accurate picture of the pressures and made clear that extra capacity was in fact available, which is exhibited at **M3VGE01/098 - INQ000396060**.

Supply issues

Oxygen

208. Dr Goodall has provided a detailed account of the oxygen supplies available in Wales and the attempts made to increase them (see M3-WGO-01 at paragraphs 380-398).

209. I recall the Welsh Government having to address a number of supply issues, in particular, matters concerning the supply process. In March 2020 there was a feeling among the devolved governments that we were being excluded from the UK/NHS England arrangements which was fundamentally affecting the Government's ability to properly plan.

210. As described by Dr Goodall the actions and liaison required to build oxygen capacity were managed by the Royal Engineers, the NHS Wales Shared Services Partnership-Specialist Estates Services and the British Oxygen Company. This process was successful and a report in June 2020 by NHS Wales Shared Services Partnership -Specialist Estates Services found that there had been a 75% increase in oxygen provision despite a number of major challenges, a copy of which is exhibited at **M3VGE01/099 - INQ000227170**.

211. The report noted that during the early stages of the pandemic the Department of Health and Social Care contacted the main suppliers in the oxygen healthcare market across the UK to centrally coordinate and control requests from across local healthcare providers in England. Healthcare providers were subsequently instructed by the Department of Health and Social Care to direct all requests for oxygen through NHS Improvement. On this basis the Department of Health and Social Care established a priority list of oxygen improvement projects for England. This arrangement was not initially communicated to the Welsh Government, the NHS in Wales or the NHS Wales Shared Services Partnership-Specialist Estate Services. Consequently, when Health Boards in Wales became aware that their existing systems could not deliver the level of oxygen needed, the British Oxygen Company was contacted to request enhancements to their systems only for the Health Board to be referred to the Department of Health and Social Care's priority list. The report concluded that this

confusion potentially delayed decision-making and could have had a detrimental impact on the ability of the NHS in Wales to manage Covid-19 patients.

212. I was advised in an email from Dr Goodall on 27 March 2020 that there were examples of suppliers, including Welsh suppliers, who had been advised to only accept contracts and block contract arrangements from NHS England. For example, the British Oxygen Company would only deliver oxygen to areas prioritised by NHS England. I exhibit a copy of this email at **M3VGE01/100 - INQ000479929**. This had to be quickly recovered by Welsh Government officials but the language being used meant that the NHS in Wales was not seen to be a priority. I understand that Dr Goodall raised this issue within the Department of Health and Social Care.

213. The NHS Wales Shared Services Partnership-Specialist Estates Services report concluded that the Welsh Government recognised the value of clear decision-making and fulfilled a similar role in Wales as the Department of Health and Social Care did for England. This involved working closely with Health Boards and the NHS Wales Shared Services Partnership-Specialist Estate Services to understand the challenges and system limitations to enable a list of priority sites to be established for enhanced oxygen provision. The Welsh Government, assisted by the NHS Wales Shared Services Partnership-Specialist Estate Services, negotiated with the British Oxygen Company to establish options, agree delivery timescales and monitor progress on site.

214. NHS Wales Shared Services Partnership had an Oxygen Delivery Group and I am not aware of any further issues relating to oxygen supply raised with me.

Medicines

215. During the first wave of Covid-19 the increased demand for critical care put significant strain on the supplies of supportive care medicines such as anesthetics, analgesics and sedatives. In Ministerial Advice dated 29 April 2020 and exhibited at **M3VGE01/101 - INQ000361554** I was asked to agree to a methodology for allocating stocks of critical care medicines at the highest risk of being in short supply during Covid-19. I was advised that as many as 20 medicines routinely used in critical care were in short supply because of the increased global demand. As a result of concerns around supply during wave one, the Department of Health and Social Care undertook

work with NHS England and Improvement and devolved governments to assess whether there were specific products, which if not supplied, had an adverse impact on NHS frontline workers' ability to deliver services.

216. To ensure the UK had sufficient stocks of those supportive care medicines in its response to any future waves of Covid-19, the Department of Health and Social Care identified a list of products that could be stockpiled to mitigate concerns around supply.

217. In August 2020 I agreed to the Welsh Government's participation and costs of Wales' population share of a UK-wide Covid-19 medicines stockpile. Additionally, I agreed to the upgrade of a storage facility in Wales to hold the Covid-19 medicines stockpile and to improve NHS Wales's resilience by creating a storage facility with capacity to hold any medicine including those requiring refrigeration and secure/controlled storage.

218. In December 2020 the UK Minister for Health confirmed to me in writing that Devolved Governments would not be asked to contribute to the costs of procuring medicines for a Covid-19 stockpile, which I exhibit at **M3VGE01/102 – INQ000492817**.

Ventilators

219. Dr Goodall has explained the process and actions taken to monitor and increase the capacity of ventilators in Wales (see M3-WGO-01 at paragraphs 379 – 391).

220. On 5 April 2020 I made a Written Statement exhibited previously at **M3VGE01/090 - INQ000182395** which confirmed that Wales currently had 415 invasive ventilation ventilators, 349 anesthetic machines with ventilator capacity and 207 non-invasive ventilators. An additional 1,035 ventilators were being procured through UK arrangements.

221. As set out above, I provided an update on the procurement process in my statement of 29 April 2020, which I exhibit at **M3VGE01/094 - INQ000227110**

a) Of the 385 invasive ventilators we expected to receive via UK arrangements, which was subsequently revised to 461, we had received 46.

b) Of the 270 dual purpose (invasive or non-invasive machines) procured by NHS Wales Shared Services Partnership, 130 had been received and distributed to Health Boards.
c) Of the 380 non-invasive ventilators which we expected to receive via UK arrangements, which was subsequently revised to 369, we have received 177.
d) The delivery of the ventilators procured through both the NHS Wales Shared Services Partnership and UK arrangements was always on a phased basis over a 13 week period, based on the original projection of a peak occurring in June/July
e) There was always sufficient ventilator capacity within the NHS in Wales.

The NHS immigration health surcharge

222. I understand on the 21 May 2020, the then Prime Minister asked the Home Office and the Department for Health and Social Care to exempt health and care workers from the NHS Immigration Health Surcharge "as soon as possible". The exemption only applied to non-EEA migrants but would extend to EEA migrants following the end of freedom of movement on 1 January 2021, when the new Points-Based Immigration System came into effect.

223. A further announcement was made by the Prime Minister on 17 June that those who had paid the Immigration Health Surcharge since the announcement would be refunded, and UK Government agreed to backdate this to the 31 March 2020.

224. The Department for Health and Social Care sought my agreement to the reimbursement of the Immigration Health Surcharge paid by health and care workers from 31 March through a 4-nation agreement under one administration, run jointly by Department Health and Social Care, the Home Office and the Devolved Governments. On 7 September 2020 I agreed on the operation and delivery of reimbursements to those exempt from the Immigration Health Surcharge through a 4-nation agreement under one administration, run jointly by the Department for Health and Social Care, the Home Office and the Devolved Governments. Other than my agreement to operate

the system under one administration I played no part in the decision, powers in relation to immigration are reserved to the UK Government.

Telephone Services

225. The Welsh Ambulance Service Trust is the sole national provider of 999 Emergency Medical Services ("EMS") in Wales and provides the call handling, clinical assessment and advice functions of the NHS 111 Wales service.

226. The NHS 111 online and telephone service was available during the pandemic and played an important role in protecting our vital primary care and emergency department services from undue demand. The service was expanded to cover the whole of Wales in April 2022. The dates on which the service was rolled out to Local Health Boards are set out below:

a) Swansea Bay University Health Board - 2 May 2017
b) Powys Teaching Health Board – 3 October 2018
c) Hywel Dda University Health Board - 31 October 2019
d) Cwm Taf Morgannwg - 24 November 2020
e) Aneurin Bevan University Health Board - 5 May 2021
f) Betsi Cadwaladr University Health Board - 22 June 2021
g) Cardiff and Vale University Health Board - 16 March 2022

227. Expanding 111 capacity was the responsibility of the Welsh Ambulance Service Trust and NHS 111 Wales programme team who held information on capacity levels and efforts to increase capacity throughout the pandemic. As Minister for Health and Social Services I was not involved in this.

228. The Welsh Government did encourage Health Boards to develop 'contact first' services at the outset of the pandemic. The Community Framework put in place March 2020 was developed and approved by the Covid-19 Planning and Response Group via the Primary and Community Care subgroup. The Community Framework included a clinical pathway for the assessment, management and escalation of Covid-19 disease. Individuals were expected to initially utilise the NHS Wales online Covid-19 symptom checker and follow the advice provided. If an individual could not cope with

their symptoms at home, had a worsening condition or did not get better after 7 days they were asked to call NHS 111 or their General Practitioner for a telephone or video assessment. Following assessment, the patient could be triaged as requiring selfcare at home with support from the community teams or escalated to acute hospital care. Local Health Boards were responsible for implementing this framework, this included ensuring that there would be senior expert advice readily available by telephone.

229. These arrangements were separate to the Covid-19 Clinical Assessment Service (CCAS) in England which was established to provide clinical advice from GPs to the public during the pandemic but operated on a similar basis.

230. In terms of any issues brought to my attention regarding 111 or similar telephone triage services I do not recall anything raised directly with my office however I understand that the Chief Medical Officer (Wales) was understandably concerned that the public message to isolate at home with mild symptoms may have encouraged people to attempt to cope alone for too long without contacting 111 or their GP. As a result of these concerns there was a change in our public messaging around August 2020 to encourage people not to attempt to cope on their own with anything more than short lived, mild symptoms.

The Covid-19 Moral and Ethical Advisory Group

231. On 1 April 2020, I was asked to agree to the establishment of a Covid-19 Moral and Ethical Advisory Group for Wales (CMEAG-Wales), to be sponsored jointly by myself, the Deputy Minster and Chief Whip and Minister for Housing and Local Government, to coordinate ethical guidance for public services in Wales relating to the Covid-19 emergency response.

232. Within the Ministerial Advice, exhibited as **M3VGE01/103 - INQ000097679,** I was informed that as part of our response to the Covid-19 emergency, there were large amounts of rapidly emerging guidance documents being produced across many health and care agencies. At UK level, the advice confirmed that the 4 Chief Medical Officers commissioned a UK Moral and Ethical Advisory Group (UK-MEAG) which had published an ethical framework setting out high level principles and values to be

applied, to minimise harms of any sort during the Covid-19 pandemic, especially should it become necessary to prioritise access to intensive health care.

233. The Royal Colleges and NICE had also produced a huge number of topic and specialty specific guidance documents. These were expert and well-intentioned but could produce conflicting advice and so become a source of confusion and upset for professionals and patients alike.

234. There was subsequently a need to establish a group in Wales to coordinate those multiple sources of guidance to ensure they met ethical standards, reflected the needs of all communities across Wales, so as to support their implementation according to the specific requirements of public services in Wales. This required a new group, which was suggested to be convened as the 'Covid19 Moral and Ethical Advisory Group Wales (CMEAG-Wales)' and would report to the Chief Medical Officer (Wales) and sponsoring Ministers. I exhibit the Written Statement made by me, the Minister for Housing and Local Government and the Deputy Minister and Chief Whip on 14 April 2020 on the work of the Group as **M3VGE01/104 - INQ000349329**.

235. The principles of mutual aid across UK services were well established but if it became necessary to escalate to using extreme surge guidance across the UK, this decision would be made by the 4 Chief Medical Officers taking advice from MEAG-UK. However, Welsh services would still need to operationalise such a step equitably and efficiently across Wales, and front-line services would need to be prepared and confident in applying such principles. Therefore, to minimise harm from prolonged grief around bereavement, there was an urgent need to bring together the wide range of ethical, faith and cultural viewpoints to enable access to specific requirements around death rituals. It was envisaged that his group would be able to coordinate and advise on agreed minimum faith-based requirements to minimise the risk of inadvertent offence or harm. The group would aim to ensure that risk of unfair discrimination towards any part of the community was reduced or removed by ensuring that officials had the right input from relevant experts including from communities more likely to be adversely impacted by Covid-19 and the emergency response.

236. I was told the Group could be convened rapidly and informal discussions between officials and relevant stakeholders established there was a need for such a group. As well as addressing potential concerns, it was a key mechanism in ensuring effective dissemination of Covid-19 public health messages communities across Wales.

237. The Group gathered and coordinated issues relating to moral, ethical, cultural and faith considerations, and provided a source of advice to public services on issues arising from the health and social care emergency response to the Covid-19 pandemic. The Covid19 Moral and Ethical Advisory Group Wales would also offer consultation and advice to Welsh public services on moral, ethical, cultural and faith considerations relating to health and social care delivery, in light of guidance from a range of sources. This included the UK Moral and Ethical Advisory Group's independent advice to the UK Government and Chief Medical Officers, NICE, Royal Colleges, professional bodies, and any relevant matters referred to it. The advice would then be used to inform equitable and just management of health-related incidents across Wales, including Covid-19 and pandemic flu as appropriate. I agreed to the recommendation which I exhibit at **M3VGE01/105 - INQ000097617**.

238. As noted above, the Welsh Government subsequently convened a Covid-19 Moral and Ethical Advisory Group for Wales. The group met for the first time on 6 April 2020 and considered a draft document taken from principles published by the UK Moral and Ethical Advisory Group, which had been convened to advise the four UK Chief Medical Officers on ethical issues relating to Covid-19. The group were asked to help develop the 'values and principles' document which had been urgently requested by the NHS in Wales to support the challenges in responding to the pandemic. Significant improvements were suggested at this first meeting, improving the emphasis on Wales-specific values and legislation, including the commitment to a Social Model of Disability, and legal protections from equality and language legislation. Those points were incorporated into a further draft considered at the second meeting on 9 April 2020.

239. The group discussed the framework at a further meeting on 9 April and attendees were in agreement that the document had evolved significantly following the initial meeting. Issues were raised in relation to the tensions between the medical and social

models of care and disability advocates were satisfied that the guidance was now providing a clear framework to enable the protection needed. As well as agreeing the draft subject to minor final edits, the group suggested the need for a mechanism to support and implement the use of this guidance in clinical practice. The group would also focus on the promotion of clinical ethics support for clinicians in Health Boards and Trusts across Wales, as a mechanism to ensure that these values and principles were used to inform clinical practice.

240. The then-First Minister, the Minister for Housing and Local Government and I were asked to agree the revised values framework so that it could be published as soon as practicable to support the sector. I exhibit the Ministerial Advice seeking my agreement at **M3VGE01/106 - INQ000271484,** the framework as **M3VGE01/107 - INQ000271483**, and a Written Statement providing an update on the group's work as **M3VGE01/104 - INQ000349329**. The framework reiterated the importance of consultation particularly around end-of-life care and DNACPR.

241. The Covid19 Moral and Ethical Advisory Group Wales developed and drafted the following documents which informed the decisions and decision-making processes for healthcare. Its informed the work of other groups in Wales, including essential services restart, intensive care and hospital policies, vaccine administration, and other health and social care interventions:

a) Framework of ethical values and principles for healthcare- April 2020, exhibited at **M3VGE01/108 - INQ000479933**
    i. Respect
    ii. Minimising the overall harm from the pandemic
    iii. Fairness
    iv. Working together
    v. Reciprocity
    vi. Keeping things in proportion
    vii. Flexibility
    viii. Good decision-making

b) Restart: Applying the Framework of Values and Principles for healthcare, June 2020, exhibited at **M3VGE01/109 - INQ000479949** which identified the principles underlying management and prioritisation in a second surge of Covid-19 cases would be:

   i. In the event of a renewed surge of Covid-19 cases and hospital admissions, Local Health Boards and Trusts should not discharge any in-patients to care homes or the community without first excluding Covid-19.

   ii. Treatment decisions should be coproduced with patients, fair and in line with the stated values and principles. Nobody should be denied treatment solely on arbitrary factors like age, disability or underlying illness.

   iii. Treatment decisions should include evaluation with the patient of the risks from Covid-19 prevalence of all aspects of: their condition, the treatment and service deliver with specific informed consent.

c) The Review of Extreme Surge Guidance in December 2021, exhibited at **M3VGE01/110 - INQ000480046** post-dated my time as Minister for Health and Social Services.

Use of Technology

242. In September 2019 I had announced details of how £50m funding would be spent to transform digital health and care services in Wales. This included a pilot of video consultation undertaken by the Technology Enabled Care programme, TEC Cymru. On 11 March 2020 I authorised the accelerated roll out of national video consultation services to ensure patients could still receive face-to-face care if they were self-isolating. I exhibit the Ministerial Advice I approved as **M3VGE01/111 - INQ000226926** and the Written Statement confirming the decision as **M3VGE01/112 - INQ000469843**.

243. The Welsh Government recognised video consultations would not replace all in-person contact, not least because there would be specific groups, including but not limited to the elderly, for whom this would not be appropriate. For that reason, on the same day as the announcement Dr Andrew Goodall wrote to General Practitioners

noting that there would still be a need for physical assessment on occasions, but it would be more targeted. He also stated that consideration would need to be given to vulnerable groups and those who did not have internet access. The letter is exhibited as **M3VGE01/113 - INQ000395690**.

244. On 17 March 2020 the Welsh Government wrote to General Practitioners outlining changes to the GMS contact. Practices were encouraged to ensure patients did not arrive at a surgery without appropriate triage, which was to be undertaken by a senior clinician or by whomever could most effectively decide who needed a physical assessment. I exhibit the letter as **M3VGE01/114 - INQ000468912**.

245. On 23 March 2020 a press release was published to re-emphasise these changed ways of working to the public. This noted that face-to-face appointments with a healthcare professional would only be confirmed after an initial telephone or video consultation. I exhibit this as **M3VGE01/115 - INQ000479928**.

246. As part of the rollout of the national video consultation service, Technology Enabled Care Cymru also worked with Digital Communities Wales to provide iPads to care home residents. I exhibit at **M3VGE01/116 - INQ000136772** MA-VG-1147-20 where I approved funding of £553, 080 and a contingency of up to £250,000 for the device loan scheme. As of June 2020, 745 devices had been delivered to 401 care homes, with 313 care homes receiving staff training on the NHS Wales Video Consulting Services. This is outlined in a press release exhibited as **M3VGE01/117 - INQ000469008**.

247. Under MA/VG/1225/20 and exhibited at **M3VGE01/118 - INQ000136773** I agreed to the rapid expansion of NHS Wales Video Consultation Service into Secondary and Community Care Sectors. This was driven by a need for video consultation services in response to the Covid-19 pandemic and for the long-term change in the way the NHS services were delivered.

248. The increased role of technology in primary care, and particularly the increased provision of video consultations, was an essential part of the Welsh Government's initial response to the pandemic. It was necessary to ensure both patients and staff

could feel safe when receiving and giving care. It is also important to note video consultations were not the only way patients were seen, they were one of a range of tools to ensure access to GPs. Practices were encouraged to consider how to care for vulnerable groups and those who might not be able to access video consultations, and physical assessment remained available.

249. The Welsh Government recognised, during this process that there was a clear danger that the most deprived people in Welsh society might be left out of a solution like this. The Welsh Government was committed to working with the digital inclusion programme to reach out to the digitally excluded population and to concentrate on places such as care homes where mobility was an issue in accessing GP services.

Field Hospitals

250. In accordance with their statutory duty, the need for field hospitals and the capacity of field hospitals were established at the Health Board level, having taken into account the local population needs for their area and the anticipated impact of the virus on capacity levels in their local area. Each Health Board developed its own local plans for building the extra surge capacity required either by using existing hospital sites, private healthcare providers or through the creation of field hospitals having received guidance from the Welsh Government about the need to increase bed capacity based on the reasonable worst case scenario modelling. At that time, it was envisaged that approximately 10,000 beds would be required across Wales to manage a peak in May/June 2020. A detailed explanation of the field hospitals established and their locations is included at M3-WGO-01 at paragraphs 488-551.

251. As Minister for Health and Social Services, my role in the establishment of field hospitals flowed from the duty to provide funding and strategic oversight for NHS services in Wales.

252. On 27 March 2020 I approved capital funding of up to £8m for equipment and enabling works for a 2000 bed field hospital at the Principality Stadium. The Ministerial Advice, which I exhibit as **M3VGE01/119 - INQ000338229**, noted that the scenarios considered by NHS demand modelling all identified a need for significant increased

capacity, with projected increases in patients requiring ventilation and/or oxygen exceeding capacity available to the NHS at the time. It also noted experience from other countries showed many forms of temporary capacity being utilised.

253. To help enable the provision of field hospitals the Minister for Housing and Local Government announced details of emergency permitted development rights allowing local authorities to change the use of buildings or erect temporary structures on their land without planning permission. I exhibit a press release dated 31 March 2020 as **M3VGE01/120 - INQ000480044**.

254. On 5 April 2020 I issued a Written Statement providing an update on field hospitals which noted they were set to create additional capacity in the region of 7,000 beds. I exhibit that statement as **M3VGE01/121 - INQ000182396**.

255. The increased cost of the field hospital at the Principality Stadium detailed in MA/VG/1223/20, which I exhibit at **M3VGE01/122 - INQ000349280** was discussed in the Star Chamber on 7 April 2020 (minutes exhibited at **M3VGE01/123 - INQ000320794**) and on 20 April 2020 (minutes exhibited at **M3VGE01/124 - INQ000299240**). On 20 April 2020 the group noted that at that time there was unused capacity in Wales without the field hospitals. Plans for the Principality Stadium were therefore scaled back. The Star Chamber asked for revised capacity plans to help to understand projected need, including the latest modelling on the progress of the disease and the need for beds. On 22 April 2020 myself, the Chief Medical Officer (Wales) and Dr Goodall attended the Star Chamber to answer the concerns. It had been possible to mitigate demand in the system, but it was expected that some of the beds in the Principality Stadium would be required as early as that week. It was not possible to be confident about what the Covid-19 situation would be in three months. There was uncertainty in the modelling. If there was a second or third peak, the field hospital provision may well be needed. For the time being, it was unlikely we would need fully to deploy, and staff, the field hospital capacity, but the infrastructure was required to be in place. People requiring NHS care but who were currently avoiding hospitals, would need support soon. To address this the NHS would need additional capacity. There was also the geographical spread of the outbreak to consider. While

there had been some levelling off in cases in south east Wales, it could be expected to continue to spread in south and west Wales, and in north Wales too.

256. The Chief Medical Officer (Wales) agreed that the field hospital capacity was necessary, as it was unclear what was going to happen in the future. Work was underway on how best to use the field hospitals. One option under consideration was to support social care homes by providing 'step-up' and 'step-down' facilities. The NHS also needed to return to providing its range of services again. Much of the Welsh hospital estate was not conducive to operating Covid-19 and non-Covid-19 provision alongside each other, so the field hospital would help to keep these streams of activity separate to ensure infection control.

257. Dr Goodall explained that the realistic worst-case scenario suggested that an additional 10,000 beds would be required across Wales. However, it had proved possible to make over 3,000 beds available in existing hospitals, so the target had been lowered to 6-7,000. There had been a need to ensure the NHS was prepared. When the projected peak in June was brought forward to April, the plans had been accelerated. During the construction phrase, some areas went for a single site option, as in Cardiff, while others chose a distributed model. This depended on local choices and facilities. It was important to differentiate the preparation and construction phase from the operational phase. The extent to which the sites were operationalised could be phased, to mitigate operational running costs. However, concern remained about a second peak in June/July and a third peak possibly as late as December. The Welsh Government was starting to look at an exit strategy with Local Health Boards.

258. I recognised that this was an extremely difficult time to manage expenditure and the level of uncertainty was a challenge - far greater than in normal times. It was not possible, at that point, to say what the position would be in December, however it was important to maintain capacity.

259. On 23 April 2020 the Star Chamber confirmed that it was content with the revised Ministerial Advice relating to the establishment of the field hospitals, subject to additional detail requested to distinguish the setup costs from the operational costs. I exhibit a copy of the minutes at **M3VGE01/125 - INQ000299243**.

260. Outside of the pandemic Health Finance scrutinises expenditure of the NHS in Wales. With the pace and volume of additional funding requests arising during the pandemic the Star Chamber provided an important additional level of scrutiny of the field hospital proposals and costings to ensure that the Welsh Government expenditure was appropriate and effective.

261. As a result, on 27 April 2020 I agreed to the immediate implementation of additional capacity to meet the estimated first peak of demand, and the Minister for Finance and Trefnydd agreed funding of up to £79m to meet the set up and construction costs of the Principality Stadium field hospital and up to £87m for the set up and construction costs of the remaining field hospitals across Wales. The Ministerial Advice, which I exhibit as **M3VGE01/126 - INQ000338232**, contained a summary of all schemes and set up costs along with beds being provided.

262. The Grange University Hospital in Cwmbran had been due to be open in March 2021. Parts of the hospital were made available early as a field hospital to support the Covid-19 response, and on 27 August 2020 I announced it would officially open in mid-November 2020 instead of the original March 2021 date. I exhibit the Written Statement as **M3VGE01/127 - INQ000480051**.

263. On 16 July 2020 I received Ministerial Advice along with a high-level review of field hospitals. I exhibit these documents as **M3VGE01/128 - INQ000235939** and **M3VGE01/129 - INQ000227392**. The review noted that while field hospitals were largely unused at that point they remained an essential option to support existing capacity.

264. On 11 September 2020 I received MA-VG-3011-20 which was a draft Written Statement about the surge / additional capacity plans of all Health Boards to use field hospitals to deliver planning assumptions informed by the potential realistic worst-case scenario for the remainder of 2020/21. I exhibit a copy of this Ministerial Advice at **M3VGE01/130 - INQ000136817**.

265. On 14 September 2020 I announced £33m for a new facility providing 400 extra beds to be built next to the University Hospital of Wales in Cardiff, following the decommissioning of the field hospital at the Principality Stadium. The Ministerial Advice has been previously exhibited as **M3VGE01/087 - INQ000235914** and the press release is exhibited as **M3VGE01/132 - INQ000480082**.

266. On 29 September 2020 I issued a Written Statement providing a further update on field hospitals and NHS capacity. This statement noted that the great majority of additional beds that were set up had not been needed, primarily because of the other measures to restrict the spread of the virus that were in place. It also acknowledged it was likely additional capacity was highly likely to be needed in the winter and confirmed Health Boards had been asked to retain 5000 beds to enable the safe management of a potential realistic worst case scenario. I exhibit this statement as **M3VGE01/133 - INQ000253705.**

267. I exhibit at **M3VGE01/134 - INQ000227274** a briefing I received on 26 November 2020 on the use of field hospitals from Dr Goodall:

a) 19 field hospitals were set up at the start of the pandemic and in a matter of weeks provided thousands of additional beds for a predicted increase in hospital admissions. Thankfully they were largely not needed.
b) During the first wave two field hospitals were used by Health Boards- Cardiff and Vale and Hywel Dda.
c) At that time three of the ten remaining field hospitals were operational. Some had not received Covid-19 patients but had been utilised in other ways (e.g. storage, training and testing hubs).

268. Once field hospitals were built and funded, the operational decisions about how they should be used lay with the Health Boards and not with the Welsh Government.

269. As the pandemic developed field hospitals were used in a different way than first anticipated. In the first wave we established field hospitals because we anticipated having to deal with a reasonable worst case scenario with capacity needed for end-of-

life care, rather than rehabilitation and recovery which became more of the focus of field hospitals. I outlined this in response to questions from the Senedd's Health, Social Care and Sport Committee on 3 March 2021 and I exhibit the transcript as **M3VGE01/135 - INQ000088005**.

270. In order to discharge the Welsh Government Ministers' duty to exercise oversight of NHS services in Wales the Welsh Government monitored field hospitals as part of the broader monitoring of Health Board performance during this period. The reporting route for field hospitals, and broader additional/surge capacity requirements beyond field hospitals, was through the Acute Secondary Care Sub-group. This group reported to the Chair of the Planning and Response Group.

271. More than 930 patients had been admitted to a field hospital by 22 March 2021, as noted in the 'Review of Field Hospital: Phase 2' Written Statement which I exhibit as **M3VGE01/136 - INQ000421679**. The statement outlined how the additional staff and bed capacity had been instrumental in enabling recovering patients to leave acute hospitals, in turn freeing up much needed capacity in acute and community hospital sites. It also set out that while many field hospitals had been opened for patients, others had been used to support the Covid-19 response in other ways – providing additional space as vaccination centres, testing hubs and training facilities. I also noted that a reduction in system pressures had lessened the requirement for field hospital capacity, and that the Welsh Government was asking Health Boards to consider whether facilities should be maintained.

272. I am asked about Welsh Government lessons learned reviews relating to Field Hospitals. Reviews were conducted relating to the governance (by the Welsh Government Audit and Assurance Risk Committee), financing and contractual arrangements (by Deloitte) and the documentation created (by the Internal Audit Service). I am also aware that the NHS Shared Services Partnership prepared *"Findings and Lessons learned in Estates and FM related matters on the NHS Wales Covid 19 Field Hospitals Programme"* in August 2021 which I exhibit at **M3VGE01/137 – INQ000421883**.

273. I am asked whether field hospitals provided value for money but I do not believe that this is simple monetary calculation. We did not ultimately utilise the full field hospital capacity due to the success of measures taken by the Welsh Government to manage the outbreak, including lockdown, social distancing and shielding of vulnerable people helped to ensure that capacity in acute and community hospital settings were not compromised and reliance on the use of field hospitals was therefore limited.

274. At the time that field hospitals were established there was clear advice that the likely pressures on the NHS in Wales would be significant. With the novel nature of the pandemic and so much remaining unknown about the virus, we could not take the risk that the pandemic would develop in a way which left hospitals overwhelmed and patients without beds. I believe it was the right decision to establish the field hospitals. They should be considered in terms of risks addressed not just beds used.

275. In order to ensure that Welsh Government funds were well used during the pandemic Dr Goodall wrote to Local Health Boards on 24 April 2020 (as exhibited at **M3VGE01/138 - INQ000395661** endorsing that they did not commission and operationalise field hospital capacity unless it was needed. As confirmed in this letter any such decisions were to be based on a local assessment of need across health and social care in the local area. Health Boards were also asked throughout the life of the field hospitals to review their local circumstances and needs, to identify any change in their need for field hospital capacity. By the end of September 2020 ten field hospitals across four of the Health Boards in Wales were retained. By the end of 2020 only four field hospitals were operational.

276. In my view the evidence does show that the use of field hospitals in the 'step-down' model of care we established – with acute care delivered in existing hospital sites and field hospitals protecting capacity and flow by supporting patients recovering from Covid-19 who weren't yet ready to return home – alleviated pressures on NHS hospitals when it was required. If those patients who were treated in or utilising field hospitals had been forced to stay in hospital that would have affected them individually and had an effect across the wider system.

Private Hospitals

277. As stated above, the modelling we received and the advice from Dr Goodall early in the pandemic was that, based on the realistic worst case scenario it was essential to quickly increase capacity in the NHS in Wales. Commissioning from the independent sector was an important part of this. Dr Goodall has summarised the number and type of beds commissioned from the private sector. Private hospitals were used to provide additional outpatient, diagnostic and inpatient capacity for non- Covid-19 care. They were not used to treat patients with Covid-19.

278. I acknowledged the role of independent hospitals as well as private and voluntary sector partners as part of a Written Statement in April 2020 exhibited above at **M3VGE01/121 - INQ000182396** as preparations for an anticipated peak were underway.

279. Neither I nor the Health and Social Services Group negotiated or agreed contracts with independent providers, the Welsh Health Specialised Services Committee (WHSSC) led the contractual arrangements. The funding for this process was provided by the Welsh Government and approved by me as Minister for Health and Social Services. As with field hospitals, once the Welsh Government funded and the Welsh Health Specialised Services Committee secured the private capacity it was for the Health Boards to decide how that capacity would be used based on local needs. I cannot, therefore, comment in detail on how the capacity was utilised or how those operational decisions were made.

280. On 25 March 2020 I agreed funding up to £30m towards the cost of commissioning additional capacity from the independent sector. The Welsh Health Specialised Services Committee had been undertaking work to identify extra capacity, meeting with the Independent Healthcare Provider Network and engaging with Health Boards and NHS Trusts. The expectation was capacity would be made available rapidly. I exhibit the advice as **M3VGE01/139 - INQ000235899**.

281. On 7 April 2020 I received further Ministerial Advice on procuring additional mental health in-patient capacity from the independent and voluntary sector. It was noted the

ability of Local Health Boards to manage the demand for specialist and non-specialist mental health in-patient beds was likely to be compromised by pressures from Covid-19. 125 beds from the independent and voluntary sector had been identified for purchase and I was asked to approve £6m to cover five months of provision. Three options were presented – seeking to manage with the existing bed stock, local management, and National Commissioning – I agreed to National Commissioning in line with the recommended advice. I exhibit this as **M3VGE01/140 - INQ000136777**.

282. In June 2020 I was asked to agree further funding for four Health Boards to extend their contracts with independent providers by up to two months to ensure the NHS had the urgent capacity required during the Covid-19 outbreak, and to allow time for alternative contracts to be put in place. I exhibit this Ministerial Advice as **M3VGE01/141 - INQ000144923**. The extension was required to enable the four Health Boards to progress their plans through the Covid-19 outbreak and also manage the urgent and other non-Covid-19 work. The funding was for Cardiff & Vale, Cwm Taf Morgannwg, Hywel Da and Betsi Cadwaladr. In addition, the Velindre NHS Trust was looking to commission the Rutherford Cancer Centre for priority cancer services.

a) Cwm Taf Morgannwg's key service need was to continue the urgent cancer work and support increasing urgent elective workload, which was an increasing pressure point. The plan was to increase utilisation significantly and utilise the diagnostic capacity available;
b) Cardiff & Vale University Health Board identified the additional capacity as important to help it build further on the strong level of use already seen, with additional services added including catheter lab facilities. The role of the hospital was to provide a 'green' space for cancer surgery and providing additional operating capacity more generally.
c) Hywel Dda emphasised the importance of the capacity in delivering cancer surgery and ophthalmology, together with its potential role in supporting the overall capacity needs of the Health Board in respect of urgent elective and elective activity.
d) Betsi Cadwaladr required the extension to support both priority 2 and priority activity. Consideration was given to the value for money against the

activity, and the Health Board worked through its demand and capacity plans alongside its financial plans.

283. On 7 September 2020 I approved the allocation of £14.7m for the independent sector as part of a £371.4m funding distribution to Local Health Boards. This is outlined in Ministerial Advice which I exhibit as **M3VGE01/142 - INQ000337101**.

284. On 17 September 2020 I agreed to a further extension in the commissioning of independent health sector capacity. This was necessary to enable Cardiff & Vale University Health Board, Cwm Taf Morgannwg University Health Board, Hywel Dda University Health Board and Betsi Cadwaladr University Health Board to extend contracts with independent providers. I approved £7.4m funding to enable this and exhibit the advice as **M3VGE01/143 - INQ000369528**.

285. I believe that utilising private hospitals was an essential part of the response to the Covid-19 pandemic in Wales. The usual capacity in Wales is significantly less relative to England. We recognised early on that additional capacity would be required and utilising private hospitals was a means of keeping non-Covid-19 healthcare available. Systems were put in place to ensure that the contracts were managed to provide value for money, including:

a) Capacity was to be paid for on the basis of actual operating costs, rather than as a fee per activity basis, and on a not-for-profit basis.
b) The agreement was adaptable for the phases of the emergency including preparatory; urgent elective, cancer and non-Covid-19 provision, extra-surge providing direct Covid-19 provision and finally phased recovery.
c) The position was regularly reviewed by the Welsh Health Specialised Services Committee on behalf of the Health Boards during Covid-19, including usage and demand, and individual contracts were put in place which resulted in a phased reduction in the use of the private facilities in a planned way.
d) The phased arrangements were designed to maximise the capacity that could be made available to the NHS at an appropriately reduced cost.

Hospital acquired infections

286. The Module 3 witness statement of the Chief Medical Officer (Wales) describes, at paragraphs 126 to 129, his communication with health bodies in March 2020 on the need to increase capacity across the NHS in Wales' estate, and assurances he sought in relation to progress on increasing isolation facilities and ventilation systems following Welsh Health Circular guidance and recommendations in 2018, and an audit in 2019.

287. I was aware throughout the pandemic that, while this modernisation work had begun, there was a need for further improvement, and hence the steps we took to increase capacity within the system which I have described earlier in this statement.

288. I am aware that Judith Paget in M3-WGO-02 has outlined from paragraph 301 the particular challenges that the ageing NHS estate posed to the implementation of infection prevention and control guidelines, and at paragraphs 310-312 the challenges relating to ventilation.

289. The Deputy Chief Medical Officer Prof Chris Jones and the Chief Nursing Officer provided joint cross-professional leadership on infection prevention and control, particularly to minimise nosocomial transmission in closed settings by drawing upon the best available evidence and relevant expertise from across the Welsh Government and the wider public sector in Wales.

290. A Nosocomial Transmission Group was established on 19 May 2020 with a wide health and social care membership and produced a range of guidance and advice for NHS and social care settings. Its purpose was to provide leadership to healthcare and care settings to minimise nosocomial transmission. The Nosocomial Transmission Group did not operate at or formally report to ministers. A detailed explanation of the structure and actions from the Nosocomial Transmission Group is included in M3-CNOW-01.

291. The process for monitoring and investigating incidents or outbreaks was refined and managed by the Nosocomial Transmission Group. A new form was issued that asked for a daily return of cases, their location, communication plans and outbreak management plan. This was sent to Public Health Wales and the Welsh Government Health Protection mailbox and copied to the co-chairs of the Nosocomial Transmission Group.

292. The Nosocomial Transmission Group's monitoring gave greater detail of where outbreaks were occurring, if they were being contained or not, and whether the interventions were working. The information gathered was shared with officials in the Welsh Government to support their response work and combined all-Wales weekly outbreak reports were prepared. These reports summarised the all-Wales and each individual Health Board position noting if the situation was stable, improving or deteriorating and noting examples of what measures were in place to respond to the situation.

293. Specific concerns or outbreaks would be brought to my attention directly. Earlier in this statement I have described the Chief Medical Officer's Incident and Outbreak updates I received. For example, in October 2020 I was informed of a new hospital outbreak in Cardiff and Vale University Health Board. I was told about the number of positive tests and the mitigating actions planned. I expressly asked to be kept informed but the determination of the correct action to be taken was for clinical leaders.

294. I received a Ministerial briefing from the Nosocomial Transmission Group dated 15 November 2020, exhibited in **M3VGE01/144 - INQ000396261**. This indicated that a substantial and frequently cited risk for nosocomial spread of Covid-19 had been the inability to achieve adequate isolation for patients with confirmed or suspected infection due to a lack of single occupancy rooms, and noted that the required 3.6m distance between beds had not been fully implemented across Wales, due to the number of beds that would have to be removed to achieve this. It stated that perspex screens were being used between beds to mitigate the risk but that this was an incomplete replacement for distancing. The briefing noted that isolation facilities available at the newly opening Grange hospital and the implementation of field

hospitals would increase capacity and thereby allow greater flexibility in separating and distancing patients.

Testing Healthcare Workers

295. At the start of the pandemic, all four nations were working to enhance their testing capacity. On 21 March 2020, Wales set a target ambition of 6,000 tests a day by 1 April, 8,000 by 7 April and 9,000 by the end of April.

296. The targets set in March reflected work that was underway by Public Health Wales to increase testing capacity and included figures from a deal Public Health Wales had with Roche Diagnostic Ltd ("Roche") to procure test kits. This agreement between Roche and Public Health Wales did not subsequently materialise. I was informed by my officials that the agreement failed due to miscommunication of Wales's position by the UK Government who were also in negotiation with Roche. Roche entered an agreement with the UK Government to supply tests and Wales was allocated a share of these – around 900 per day. This was significantly less than had been anticipated as had the agreement been with Public Health Wales, we anticipated 5000 tests for Wales. This was a source of disappointment and frustration. On 20 April 2020, the 9,000 tests by the end of April expectation was abandoned by the First Minister.

297. Throughout March and April 2020, the Welsh testing programme was significantly constrained by the availability of both antigen and antibody tests. On 15 April 2020 I commissioned a review of the testing regime to identify where improvements could and should be made. This phase of activity of the testing plan was focused on our critical workers and so, this review was necessarily focused on the testing of critical workers.

298. On 18th April 2020 the Welsh Government published that review which described a range of delays and supply chain issues and confirmed that "we will not reach 5000 tests by the 3rd week of April". I exhibit a copy of the review at **M3VGE01/145 - INQ000182403**.

299. The Chief Medical Officer (Wales) (M3-CMO-01) has provided a chronological summary of the development of the Welsh Government's testing policy which will not be repeated here. At all times the advice and the guidance about who should be tested and when came from Public Health Wales, who were engaging with the Welsh Government through the Chief Medical Officer's office. This was a difficult analysis of the availability of tests, the modelling data and the relative risks of the options involved.

300. These difficult decisions were not just a question of resource management but our understanding of the relative value of testing all staff, including those asymptomatic, and patients or residents as was set out in a Technical Advisory Cell paper, exhibited in **M3VGE01/146 - INQ000066281**, and entitled 'Core principles for utilisation of RT-PCR tests for detection of SARS-COV-2'. This paper set out the recommendation that the performance of the existing RT-PCR tests were at their best when their use was targeted. It was considered unsuited to the non-targeted screening of asymptomatic individuals, especially in populations with a low prevalence of infection.

301. I am specifically asked when Wales introduced testing of asymptomatic healthcare workers. The answer lies in the development of testing capability, capacity and strategy throughout the pandemic. As testing capacity increased the availability and prioritisation of testing for healthcare workers, in particular asymptomatic healthcare workers, increased:

a) From 18 March 2020 the testing capacity was being increased and was prioritised for healthcare workers involved in frontline patient facing clinical care.
b) The Testing Plan for Wales from 7 April 2020, exhibited in **M3VGE01/147 - INQ000338226** included blood testing of healthcare workers every 2-4 weeks to provide an estimate of developing immunity across the population.
c) The Critical Worker Policy of 18 April 2020, exhibited in **M3VGE01/148 - INQ000182402** included prioritised testing for symptomatic critical workers, including health and social care workers.
d) On 2 May 2020 the care home testing policy was expanded to target outbreak hotspots which could include testing all residents and included

targeting largest care homes. On 16 May this was extended to provide testing to all staff and residents (asymptomatic and symptomatic) of care homes with a possible or confirmed case in the preceding 28 days.

e) On 3 June 2020 the Welsh Government introduced *"A Principles Framework to assist the NHS in Wales to return urgent and planned services in hospital settings during Covid-19"* which I exhibit at **M3VGE01/149 - INQ000299363**

   i. As regards to patients this required *"Emergency Admissions: test all patients on admission. For patients who test negative, further testing will be undertaken if COVID-19 symptoms are present or develop."* and for Elective Admissions arrangements were required for pre-admission testing. In patients who become symptomatic were also tested.

   ii. All symptomatic staff members were to be tested and additional NHS testing capacity was to be used routinely and strategically to test asymptomatic frontline staff.

f) The 15 July 2020 testing strategy, exhibited in **M3VGE01/150 – INQ000083244** included *"Protecting Our NHS services – to prevent, protect and deliver testing to support the safety of staff, patients and clients".* Repeated requirement for Emergency Admissions to "test all patients on admission. For patients who test negative, further testing will be undertaken if COVID-19 symptoms are present or develop."

g) This was reiterated in the testing prioritisation that I announced on 29 September 2020, with:

   i. Priority one to support NHS clinical care and focus on hospital patients, including all admissions, so that clinical judgements could be made to ensure the best care for these individuals.

   ii. Priority three to test NHS staff, including GPs and pharmacists where possible, with protecting our NHS at the heart of our Covid-19 response and a clear priority in our testing strategy. We said we would continue to test NHS staff with symptoms and would test asymptomatic staff in outbreaks and areas of higher prevalence. Outbreaks was defined in the Wales Outbreak Control Plan 2020

and included local communities or within closed settings such as care homes, schools or workplaces. The Welsh Government is aware of local outbreaks in Wrexham in July 2020 and in Cwm Taf hospitals in October 2020 where this applied.

h) On 20 November 2020 I received a Ministerial Advice exhibited at **M3VGE01/151 - INQ000116627** and a briefing paper "Next Steps for Reducing Nosocomial Transmission of Covid-19 Infection in Welsh Hospitals and Care Homes" which I exhibit at **M3VGE01/144 - INQ000396261**. The briefing paper proposed testing of NHS staff with the purpose of identifying staff who had Covid-19 symptoms and posed a risk of infection to the vulnerable patients they cared for.

302. In November 2020 there was limited asymptomatic testing of healthcare workers in Wales but this was targeted to assist with outbreak control and in some clinical areas with vulnerable patients. Asymptomatic testing was not used routinely across high prevalence areas but was undertaken more in such areas due to outbreaks.

303. The scientific validation of and availability of lateral flow devices was critical to the ability to introduce routine asymptomatic testing of healthcare workers. Lateral flow devices were, at that time, new technologies and the UK mass testing programme piloted them to understand their use. The NHS had decided to roll out lateral flow devices to testing staff in acute, community, mental health settings and ambulance trusts. The Chief Scientific Adviser (Health) had provided verbal updates on the mass testing programme and lateral flow devices to me and the First Minister at various points in our regular meetings.

304. The routine testing of asymptomatic healthcare workers was introduced in December 2020. I agreed the advice and on 4 December 2020 gave a Written Statement which I exhibit at **M3VGE01/152 - INQ000420995**[4], setting out the new programme. We introduced a programme of regular, twice per week, asymptomatic

[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 Welsh Government and disclosed to the UK Public Inquiry [INQ000469061].

testing of patient-facing health and social care workers in hospitals and primary care and community care settings, and others who had contact with people in those settings. This testing programme included testing of staff delivering domiciliary care services and professionals visiting care homes and other social care settings.

305. In March 2021 the *"Framework for Covid-19 testing for hospital patients in Wales"* ("the Framework") was published. A copy of the Framework is exhibited in **M3VGE01/153 - INQ000081893**. The Framework set out the steps to be taken in order to prevent Covid-19 entering hospitals undetected, to prevent spread within hospitals, to reduce the risk to some particularly vulnerable cohorts of patients requiring treatment and to enable the safe discharge to home or community care. In summary this Framework required:

a) Pre-admission RT-PCR testing in all patients due to be admitted for elective treatment.
b) Implementation of the 'discharge to care home' criteria of non-infectiousness for all planned elective admissions with previous history of Covid-19 infection.
c) Robust and consistent data collection of testing practice for local and national assurance.
d) Testing of emergency admissions using LFD or suitable rapid point of care devices like Lumira DX, in addition to RT-PCR, interpreting the results in the context of the likelihood of Covid-19 infection.
e) Adherence to the NHS England standard operating procedure for emergency admissions and pathways.
f) Repeated RT-PCR test at 5 days after an initial negative result and at 5-day intervals and consider retesting at 3 and 7 days in areas of high nosocomial transmission.
g) Consideration of enhanced testing of patients who were clinically extremely vulnerable or receiving dialysis and cancer care in hospital.
h) Adherence to published Welsh Government guidance on testing prior to discharge to care homes or other health or social care facility.

306. This framework was introduced in response to advice from the Nosocomial Transmission Group exhibited in **M3VGE01/154 - INQ000136845**. The framework set out five purposes of testing to diagnose, to prevent Covid-19 from entering hospitals undetected, to prevent its spread within hospitals, to reduce risks to particularly vulnerable cohorts of patients requiring treatment, and to enable the safe discharge of patients to their home or to community care. By enabling those patients admitted to hospital who were infected with Covid-19 to be rapidly identified, clinical judgements could be made to ensure the best care for them. The ability of our hospitals to safely maintain a full range of clinical services was dependent upon the prevention of transmission of Covid-19 within hospitals. This required the separation, so far as possible, of patients with Covid-19 even if they were asymptomatic.

PPE

307. I was the lead minister responsible for Personal Protective Equipment (PPE). There was of course the additional part of PPE related to the procurement (which I understand will be considered in later modules) which Lee Waters, Deputy Minister for Economy and Transport provided additional ministerial support and challenge.

308. The pandemic influenza stockpile of PPE was crucial during the first four months of the Covid-19 response but we underestimated how quickly the PPE pandemic stockpile would be used up, how rapidly supply chains would fail and frankly that a small amount of our stockpile was not fit for purpose.

309. In terms of my role and any advice to the First Minister or other core decision makers, I made key decisions which I will outline below. The Welsh Government Health Countermeasures Group, established from 12 February 2020, worked closely with the NHS Wales Shared Services Partnership Procurement and Health Courier Services and the NHS and social care sectors in Wales to ensure availability and dissemination of PPE. We were, however, concerned about PPE supplies throughout. We had initial localised challenges in delivering through the whole system to front line staff. On 6 March 2020, I was asked by officials to agree the release of PPE from the stockpile held for Wales as part of the Influenza Pandemic Preparedness Strategy for use by GPs as soon as possible and for the NHS and social care when needed. Advice

provided to me noted concern regarding supply and in particular primary care access to PPE. A copy of this advice is exhibited in **M3VGE01/155 - INQ000298983**.

310. We had common sense systems for distribution and expanded the NHS system to provide for social care. On 19 March 2020, I set out in a Written Statement, exhibited in **M3VGE01/156 - INQ000252549**, that if PPE stock could not be accessed and while the Welsh Government prepared to distribute PPE stock to local authorities, arrangements had been made that care providers could approach Local Health Boards for urgent assistance. These arrangements were only to be utilised if a case of Covid-19 had been confirmed in these settings. The distribution of PPE stock was co-ordinated by the NHS Wales Shared Services Partnership who distributed the supply to the Joint Equipment Stores/Community Equipment Stores ("JES") that serviced local authorities. Any requests for stock would then be managed by the authority in conjunction with the Joint Equipment Stores and the care provider.

311. On 25 March 2020 I made a further statement on PPE which I exhibit as **M3VGE01/157- INQ000299063** to outline steps I took to enhance the arrangements in Wales for protecting front line health and social care staff who were caring for suspected or confirmed Covid-19 patients.

    a) Personal protective equipment from the pandemic stockpile was released to the NHS and to social care to reinforce the regular NHS supply routes that had come under substantial pressure.
    b) Health Boards were able to draw on supplies through the NHS Wales Shared Services Partnership. However, as a result of a significant increase in demand for Type 11 R fluid resistant facemasks and FFP3 respirators, I authorised a significant push of PPE to the 7 Health Boards, Welsh Ambulance Service and Velindre.
    c) Recognising that it was not normal for GPs to hold large stocks of PPE at their clinics other than for business as usual, I authorised from the pandemic stockpile a distribution of PPE (facemasks, gloves and aprons) to all 640 GP clinics and the 40 GP out of hours services in Wales.
    d) The guidance for GPs changed and there was the need for GPs to wear eye protection when dealing with a suspected or confirmed Covid-19

patients. I, therefore authorised a second distribution of PPE to all GPs clinics.

e) Pharmacies were often the first point of contact for people looking for advice on treatments before going to their GP. It was essential that we took steps to protect these key front line healthcare workers dealing every day with people who may be unwell. I authorised a distribution of PPE for all 715 pharmacies in Wales.

f) Social care had an essential role in our response to Covid-19. I authorised PPE to also be released for use by social care providers. Health Boards were providing PPE to support care centres dealing with suspected or confirmed Covid-19 cases. We enhanced those arrangements by putting in place a contingency plan for social care access to PPE through local authorities' Directors of Social Services and also put in place arrangements to monitor the use of PPE and top up those supplies when needed.

312. As we learned more about the virus, our advice and the demand for PPE increased. On the 2 April 2020, new UK PPE guidance advised *that 'All health and social care staff within 2m of a suspected or confirmed coronavirus patient should wear an apron, gloves, fluid repellent surgical mask and eye protection'*. Previously PPE was only required for the care of those people with symptoms. Additional PPE supplies beyond the provision in UK agreements was needed. On 6 April 2020 in a joint letter to social care providers in Wales, exhibited in **M3/VGE01/158 - INQ000320785**, I and the Deputy Minister for Health and Social Services stated:

'We know a lot of people are concerned about their safety and are anxious about having the right personal protection equipment (PPE). The guidance has been reviewed and been updated last week. The Welsh Government is working hard to get extra supplies of PPE to all frontline social care staff – we have delivered more than 5 million extra items of PPE from our pandemic stocks, over and above the normal supplies available. Extra deliveries have been made to local authority distribution points for onward delivery to all social care settings. We are working with the UK Government, Scottish Government and Northern Ireland Executive to secure new supplies of PPE and with businesses and manufacturers in Wales to create our own made-in-Wales supply of PPE during the coronavirus pandemic…It is important the new guidance is followed properly and PPE used as specified. For

every piece of PPE kit used unnecessarily, a piece of kit is unavailable to staff most at risk'.

313. In April 2020 a PPE Supplies Cell was added to the Health and Social Services Group Covid-19 Structure. The cell was directly accountable Welsh Ministers and the Director General of the Health and Social Services Group / Chief Executive NHS Wales. The cell had close links with NHS Wales Shared Services Partnership who provided PPE stock reports.

314. From 2 April 2020, I attended PPE update meetings with the First Minister, initially on a weekly basis and subsequently fortnightly. The First Minister and I received a written briefing ahead of the meetings which included details of the total number of PPE products supplied to date, the current stock levels by PPE type in health and social care across Wales, the numbers of items currently on order, details of recently secured stock and production levels, an update on any PPE types approaching low levels and the action being taken to secure further stock, and an update on the identification and sourcing of additional domestic and international suppliers. An example of the written briefing, dated 24 April 2020, is exhibited in **M3/VGE01/159 - INQ000198310**.

315. I also provided an answer to a Written Question on 4 April 2020 to outline the steps taken to ensure that suitable PPE was provided to hospitals and hospices by Local Health Boards- **M3VGE01/160- INQ000469844.**

316. I am aware that in April 2020 the Wales Trades Union Congress and British Medical Association Cymru issued joint statement on the need for greater clarity on the stock and supply of personal protective equipment. As can be seen from emails sent at that time, I was having regular meetings each week with the trade unions in order to discuss their concerns **M3VGE01/161 – INQ000492675**.

317. Ensuring PPE supplies for our health and social care system was one of my top priorities. I publicly noted on the 21 April 2020 that Wales had only had enough stocks of all items to last for a few days. This was partly because of the mutual aid we received from other UK countries and partly because of the UK supplies from which Wales

received its population share were such that, we were not in a position to say that we had weeks and weeks of advanced stock on all of those items.

318. This was an area in which we had made real progress during April 2020 but we were not complacent about it nor did we see it as a done deal. My advice to the First Minister and others was that we needed more PPE and that we would run out if action was not taken. On 20 April 2020, Cabinet considered the Policy Co-ordination Dashboard, as exhibited in **M3VGE01/162 - INQ000048968**, which set out the red/amber/green rating of projects. PPE supplies was rated red. On 27 April 2020, the First Minister, following discussion at Cabinet, confirmed in a Covid-19 public briefing that the Welsh Government was not relying simply on established links, but taking a multi-pronged approach to ensuring sustainable PPE supplies, including:
    a) Working with other UK nations to pool procurement efforts, bringing in new stocks and offering mutual aid in providing PPE;
    b) Procuring additional PPE supplies using the Welsh National Procurement Service;
    c) Continued international supplies, including masks from China and gowns from Cambodia; and
    d) Increased working with Welsh businesses through innovation and new manufacturing routes, to produce PPE including face shields and scrubs, with Wales approaching self-sufficiency in the latter.

319. Our procurement systems for PPE were not compromised or circumvented by a VIP lane or anything similar. PPE procurement also came alongside what we were doing to manufacture PPE in Wales. We had more and more companies that were coming online making items such as hand sanitiser and eye protection equipment. Penderyn whiskey distillery, famously, made hand sanitiser and many others were producing that too. The Royal Mint and Rototherm and others were producing face protectors.

320. We received mutual aid from Scotland and England and we provided mutual aid to England and Northern Ireland – the balance is that we provided significantly more than we received.

321. We agreed a transparent way of highlighting the data on stock. On 21 June 2020, the first of a new weekly statistics release was published by the Welsh Government to provide transparent information on PPE supplied to health and social care in Wales. The last report dated the 31 March 2022 is exhibited in **M3VGE01/163 - INQ000227378** and confirmed that since 9 March 2020, the NHS Wales Shared Services Partnership issued over 1.3 billion items of PPE to the health and social care sectors in Wales. Approximately 550 million of these were issued to the social care sector. The data also shows that the weekly number of PPE items issued generally increased from March 2020 reaching a peak of 20.2 million in May 2020. Since then, the number of items issued each week has fluctuated but generally remained around 10 million with the exception of the week ending 28 March 2021 when 31.5 million items were issued. The increase in the number of items issued for the seven days ending 28 March is due to a larger number of type IIR masks being issued for vaccination packs.

322. We were conscious that we were going to use PPE at a much greater rate across health and social care for a long time, so we would need to both procure and manufacture our own PPE in different measures. We then had to assess what the balance should be for the future in having a robust and sustainable approach to PPE provision that involved the balancing of international procurement and then to localised manufacture.

323. Throughout the relevant period we did not run out of PPE on a national level. We were of course concerned but it did not adversely affect the actual choices we made regarding non-pharmaceutical interventions and the restrictions on the public.

324. I am specifically asked about the extent to which I was engaged in the detail of or concerns about the type, quality and suitability of PPE. In particular whether I was aware of any issues relating to age, sex, race, disability, pregnancy and other relevant physical characteristics such as wearing glasses or beards.

325. My responsibility for, and involvement in PPE was predominantly about the stock available and the statistics reported to me described above. The detail about the types of PPE that were used and purchased were managed predominantly by the NHS

Wales Shared Services Partnership and the PPE Supplies Cell. The NHS Wales Shared Services Partnership's Procurement Strategy took into consideration the need to purchase a variety of PPE makes and models to ensure it was inclusive, e.g. FFP3 masks require fit testing under HSE rules (which has to be carried out by trained staff) and the NHS Wales Shared Services Partnership held data on fit test success rates of particular models to support purchasing decisions and ensure the masks met the requirement for a high proportion of staff.

326. Discussions about whether PPE fitted both men and women or those with beards would take place within the NHS Wales Shared Services Partnership and I understand that over the May 2020 - October 2020 period the need to purchase a variety of PPE makes and models to ensure they were inclusive was a consideration in discussions by the NHS Wales Shared Services Partnership and on PPE Operational Executive Lead calls.

327. As stated above, my regular meetings with Dr Goodall, Health Board representatives, NHS Chairs and Trade Unions provided opportunities for concerns to be raised with me. For example, I exhibit an email to myself at **M3VGE01/164 - INQ000299062** on 24 March 2020 with a report I had received from a consultant that it was chaos in his hospital with no protection for nurses and masks were not being released. I passed this to Dr Goodall and informed him that I was hearing specific anecdotes on a failure to provide PPE. I asked to be informed about the position. This directly informed the public statement I made on 25 March 2020 on PPE which I exhibit at **M3VGE01/157 - INQ000299063**.

Visiting Restrictions

328. Guidance on facilitating hospital visits during the pandemic was issued by the Chief Nursing Officer in the form of letters to all NHS Wales Nurse Directors on 25 March and 20 April 2020. The Chief Nursing Officer took the lead in drafting and promulgating this guidance (see M3-CNO-01 at paragraphs 338 – 349), which was provided to me after it had been issued.

329. On 15 July 2020, revised and more detailed guidance was issued, to take effect from 20 July 2020. This was prepared with the aid of a small working group from the NHS with input from officials in social services to ensure there was no inherent conflict with the visiting guidance for care homes. The guidance explained that visiting should be with a clear purpose and agreement for visiting based on the best interests of the patient/service user or the well-being of the visitor. It aimed to strike a balance between visiting and the need for robust infection prevention and control policies. It provided face-to-face visiting for those people with specific needs, as set out in the guidance, had to be agreed in advance and outdoor visits could be offered, if appropriate. The Chief Nursing Officer took the lead in drafting and promulgating this guidance (see M3-CNO-01 at paragraphs 338 – 349), which was sent to me after it was issued.

330. I was aware of concerns of Members of the Senedd and the public via social media or email, particularly over the Summer of 2020. The most commonly raised concern related to the support that could be provided during maternity appointments. I referred these to the Nursing Directorate who assisted in drafting correspondence in response to refer to or explain the guidance (see detailed summary in M3-CNO-01).

331. I understood that this was a difficult and emotive area, and I was sympathetic to those affected by it especially as it related to maternity services. I trusted the advice of the professionals and experts who were engaged in this work and the development of these guidelines.

332. The first Ministerial Advice I received on this issue was 14 October 2020 and exhibited at **M3VGE01/165 - INQ000145036**. Whilst national guidance was initially considered appropriate to ensure consistency, by this time there were significant variations in community transmission across different parts of Wales and differences in the rate of nosocomial transmission. Therefore, it was considered that there was a need for flexibility in the guidance.

333. In areas of high levels of Covid-19 transmission in the community or where there were high rates of nosocomial transmission, health care providers had already had to further restrict visiting to protect the health and safety of patients, communities and

staff. There had also been a significant amount of pressure by and on behalf of pregnant women and their partners for visiting and accompanying restrictions in the guidance to be eased. Following extensive consultation with key stakeholders from every Health Board including Heads of Midwifery and Sonography services, agreement was reached for a risk assessed methodology to be adopted to account for local service provision and adaptation to estates.

334. The following minor amendments were suggested to the main guidance which was to be the baseline for visiting in Wales during the pandemic:

a) The recognition that some people may require an essential support assistant for specific additional support e.g. a support worker or interpreter. Essential support assistants should not be seen as visitors. In some circumstances, where people received care and support from a family member or partner, they could be nominated as an essential support assistant.
b) The inclusion of people with dementia on the list of those patients permitted one visitor at a time was inadvertently omitted in the original draft of the guidance.
c) Updated Welsh Government guidelines on face coverings and face masks.

335. Principles were also introduced for pregnant women attending pre-planned antenatal appointments in Wales. A framework was developed to assist Health Boards to assess visitor access for partners, visitors and other supporters of pregnant women in maternity services during the Covid-19 pandemic. The framework was informed by the guidance provided to NHS England from the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynecologists (RCOG) and the subsequent published framework by NHS England (September 2020). It was developed in collaboration with a working group of relevant policy leads, Nurse Directors, infection prevention and control colleagues in Public Health Wales and Midwife and Sonographer representatives from Health Boards.

336. It recommended Health Boards undertook a risk assessed approach to either relax or restrict visiting according to local transmission of Covid-19, in collaboration with

relevant health professionals, local infection prevention and control teams and Public Health Wales. The guidance provided a table of risk levels against specific maternity services for Health Boards to use when determining their risk assessments. Consideration was provided to women in certain situations e.g. women with a mental health issue and the need for essential support assistants was recognised.

337. I approved the amendment of the guidelines and issued a supplementary statement on 30 November 2020 which I exhibit at **M3VGE01/166 - INQ000300096**.

Healthcare Inspectorate Wales

338. Healthcare Inspectorate Wales (HIW) is deliberately separated from the Health and Social Services Group in recognition of the importance of its professional independence and judgement. Welsh Ministers recognise Healthcare Inspectorate Wales must be able to undertake its work without prejudicial pressure or improper constraint. The Memorandum of Understanding between Welsh Ministers, the Chief Inspector of Care Inspectorate Wales and the Chief Executive of Healthcare Inspectorate Wales, **M3VGE01/167 - INQ000182578**, states the Minister for Finance and Local Government is responsible for the governance and oversight of audit, inspection and regulation as they relate to public services, including the organisation arrangements for Healthcare Inspectorate Wales (as well as Care Inspectorate Wales).

339. Healthcare Inspectorate Wales took the decision to suspend routine inspections from 17 March 2020, which I believe was necessary as the focus on inspections would have been a distraction away from the extraordinary demands of the pandemic. The restrictions and infection prevention and control guidance in place would also have made routine inspections impractical. Healthcare Inspectorate Wales concluded that the personal safety and wellbeing of its staff, staff working within healthcare settings and patients necessitated this decision. In particular it would create a risk that Healthcare Inspectorate Wales staff would transmit the disease whilst travelling between sites.

340. A Cabinet paper on resource circulated on 23 March 2020 explained that the decision would help those delivering healthcare services to concentrate all resources on keeping people safe and confirmed it was in line with the Welsh Government's framework of actions which included minimising regulatory requirements for health and care settings. I exhibit this paper as **M3VGE01/168 - INQ000048818**.

341. Healthcare Inspectorate Wales did continue to discharge its assurance and inspection role by making use of off-site activities, including Quality Checks which used self-assessments, telephone interviews and analysis of evidence to assess quality of care. Each Quality Check resulted in a report. In addition, Healthcare Inspectorate Wales did continue to conduct on site inspection where they received intelligence to suggest that there may be immediate risks to patient safety.

342. I received briefings from Healthcare Inspectorate Wales setting out the performance of certain aspects of the healthcare system. I am aware that these have been listed in and exhibited to the witness statement of Alun Jones on behalf of Healthcare inspectorate Wales.

Long Covid

343. The Welsh Government's approach to supporting the rehabilitation needs of Covid-19 patients was guided by the principle that rehabilitation services should be delivered at local level through existing primary and community care services. While we did not directly commission services we worked closely with Local Health Boards who delivered these services.

344. In May 2020 I agreed the National Framework for Rehabilitation, which guided the approach to population rehabilitation needs as part of the phased recovery of routine services. Ministerial Advice noted the framework had been developed by the Rehabilitation Task and Finish Group and would be supplemented by planning guidance for four population groups identified by the Chief Allied Health Professions Advisers. The advice is exhibited as **M3VGE01/169 - INQ000235893** and the framework is exhibited as **M3VGE01/170 - INQ000369596**. In clearing the framework, I had been keen to ensure it included prehabilitation and asked for further information

on how prehabilitation was built into our future approach and the practical consequences for system reform, including training. Officials responded to confirm the framework would be the basis for a transformation of both rehabilitation and prehabilitation, and Health Education and Improvement Wales was already looking at training needs. I exhibit this email exchange as **M3VGE01/171 - INQ000479946**.

345. I provided an update on the work we were doing to support patients with 'Long Covid' in October 2020. At that time the longer term impacts of Covid-19 were becoming clearer. In Wales we did not have plans to develop rehabilitation centres as in England. It was anticipated that it would be a relatively small number overall of people recovering from Covid-19. Instead, our approach was focused on providing care and support as close to home as possible, tailored to meet an individual's specific needs.

346. We were continuing to learn about Covid-19 at the time and I confirmed we were participating in the development by the National Institute for Health and Care Excellence of a clinical definition of Long Covid and subsequent guidance on diagnosis and care. I also confirmed Wales was participating in the UK Post-Hospitalisation Covid-19 Study which was establishing the long-term effects of Covid-19 with the aim of informing the development of care pathways. I exhibit this statement as **M3VGE01/172 - INQ000412528**.

347. I provided a further update in January 2021, as part of which I confirmed the NHS in Wales had developed and launched a Covid Recovery app to help patients manage their recovery. I also outlined that Health Education and Improvement Wales had developed a digital platform to enable access to a wide range of resources to support health and care professionals. The full statement is exhibited as **M3VGE01/173 - INQ000353384**, and the Ministerial Advice underpinning the statement is exhibited as **M3VGE01/174 - INQ000353884**[5].

[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 Public Inquiry [INQ000368786].

348. The Welsh Government had issued the Community Framework for the management of Covid-19 in March 2020, including a clinical pathway for the assessment, management and escalation of Covid-19. In November, in order to strengthen the community pathway I agreed £200,000 to extend the platform that delivered the secondary care Covid-19 guideline to incorporate the community pathway, helping to ensure health and care professionals in the community could access up-to-date Covid-19 education materials. I exhibit the Ministerial Advice underpinning this decision as **M3VGE01/175 - INQ000361635**. In March 2021 I then agreed funding of up to £216,000 for the Long Covid Pathway to be built and integrated with existing pathways – providing online national resources to health and care professionals enabling them to help and advise people recovering from Covid-19. I exhibit Ministerial Advice on the matter as **M3VGE01/176 - INQ000235884**.

349. On 22 March 2021 I issued a further Written Statement to provide an update on Long Covid in which I explained the actions taken by and on behalf of the Welsh Government and the plans for further action- **M3VGE01/177 – INQ000492874**.

350. As Deputy Minister for Health and then Cabinet Secretary/Minister for Health and Social Services in the years before the pandemic I had been involved in the All-Wales clinical policy for DNACPR - 'Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales'. It was launched in 2015 and updated in 2017 and 2020. The 2017 updated policy, in place at the beginning of the pandemic, is exhibited as **M3VGE01/178 - INQ000227411**. The 2020 updated policy, which included additional detail on Do Not Attempt Cardiopulmonary Resusication discussions, is exhibited as **M3VGE01/179 - INQ000283301**[6].

351. As the pandemic developed I was aware of some concerns around decision-making in the NHS about the use of Do Not Attempt Cardio-Pulmonary Resuscitation orders, which had been raised by representative groups, reported in the media and raised in correspondence. I exhibit an example as **M3VGE01/180 - INQ000469312**.

[6] 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 [INQ0002274141].

352. 'DNACPR guidance' was discussed at the ministerial call on 6 April 2020, where it was noted that stories about Do Not Resuscitate were causing distress to older people and disabled people. In particular, the news at that time reported on one GP surgery within the Cwm Taf Health Board that had sent patients with life limiting illnesses a letter asking them sign a Do Not Resuscitate Form. As a result of this incident, and the discussions prompted within Cabinet, guidance on Do Not Resuscitate was informed by the ethics committee and I agreed to circulate this guidance to Ministers. I exhibit the note of the ministerial call as **M3VGE01/181 - INQ000271473** and the guidance as **M3VGE01/182 - INQ000361494**.

353. As noted above, the Covid-19 Moral and Ethical Advisory Group Wales had been established to coordinate issues relating to moral, ethical, cultural and faith considerations and provide a source of advice to public services. Its values and principles framework included guidance that people should be consulted as much as possible about their care with adequate time for decision-making, especially around end-of-life care and Do Not Attempt Cardiopulmonary Resuscitation decisions. The Ministerial Advice for this framework has been previously exhibited as **M3VGE01/106 - INQ000271484** and the framework has been previously exhibited as **M3VGE01/107 - INQ000271483**.

354. On 12 April 2020 the Chief Medical Officer and Chief Nursing Officer wrote to all Health Boards and others in the NHS in Wales to highlight the new group and its framework, exhibited as **M3VGE01/183 - INQ000300105**.

355. On 17 April they wrote again following concerns from the Wales Disability Reference Group about the potential for the Clinical Frailty Scale to be used inappropriately in making decisions on escalation of care and Do Not Attempt Cardiopulmonary Resuscitation. The Older People's Commissioner had also raised concerns about the care and treatment options available to older and vulnerable people, some of whom had felt pressurised into signing DNACPR forms. The letter stated they were not aware that Do Not Attempt Cardiopulmonary Resuscitation decisions were being made purely on the basis of age, disability, learning disability, autism, mental illness or other condition, but wanted to provide reassurance to individuals living with these conditions or their loved ones. The letter stressed that age,

disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes. The Chief Medical Officer and Chief Nursing Officer also stressed that decisions should continue to be made on an individual and consultative basis with people. I exhibit this letter as **M3VGE01/184 - INQ000300106**.

356. This position was restated in a March 2021 letter which is exhibited as **M3VGE01/185 - INQ000227370**.

Effect on the healthcare workforce

357. As stated above, I spoke regularly with Dr Goodall, representatives from Local Health Boards and Trade Unions. Through them I endeavored to understand the conditions faced by healthcare workers, though I could not attend or visit hospital sites myself in the way I would ordinarily have done. I also met with the British Medical Association, with the Chief Medical Officer and the Chief Nursing Officer who led their professions in Wales. Whilst I may not have always known of specific concerns (many of which would be resolved at Health Board level or with the support of officials in the Health and Social Services Group) I was aware of the great toll that the pandemic was taking on healthcare workers.

358. Health Boards and Trusts all have mental health and wellbeing policies in place and were taking their own initiatives to support their staff. In addition, I was aware that Health Education and Improvement Wales provided a suite of resources to support healthcare workers.

359. On 16 April 2020 I announced that the Welsh Government had also extended the Health for Health Professionals mental health scheme in place for doctors to every frontline healthcare worker, which is exhibited as **M3VGE01/186 - INQ000480084**. In doing so I reiterated that *"The health and wellbeing of our all our dedicated NHS Wales staff is paramount at all times but especially so during this acutely challenging time."*

360. The Welsh Government provided an additional £1 million to support the Health for Health Professionals Wales service run by Cardiff University to employ more

psychiatrists and medical advisers, run more counselling sessions and conduct further PTSD interventions. The service offered an unprecedented level of support and advice to all healthcare professionals, including doctors, nurses, healthcare professional students, paramedics, therapists, dentists and medical volunteers working in Wales during and post the Covid-19 pandemic.

361. Staff in the NHS in Wales were able to call a confidential helpline staffed by healthcare professionals, get access to face-to-face counselling sessions and be provided with guided self-help tools and online resources. The service also supported returning retired staff and healthcare professional students who were volunteering to assist in response to Covid-19 through the COVID Hub Wales.

362. In August 2020 I announced the launch of a Welsh Government funded, bespoke Samaritans helpline which, in Wales, is dedicated both to NHS workers and the social care workforce. I exhibit this announcement as **M3VGE01/187 - INQ000480081**.

363. I recognised and appreciated the challenges and immense pressure facing our dedicated health and social care workforce at all times but particularly during that unprecedented time of personal and professional strain.

364. The service was available daily between 7am and 11pm offering confidential support tailored for individuals working in health care settings, provided by trained volunteers. In recognition of the importance of staff having the choice to communicate in English or Welsh a Welsh language service was also available between 7pm-11pm daily from the outset.

365. Individuals were dealing with a combination of personal and professional factors which were acutely different to their old 'normal' both during and after the emergency situation, so the Welsh Government worked with NHS employers, our social care partners and with the trade unions to further develop the wellbeing offer for our workforce.

366. On 16 April 2020, to avoid the introduction of inconsistent local arrangements, I agreed MA/VG/1322/20 which outlined the partnership work by NHS Wales Employers

and Trade Unions to agree a position on overtime, as the pandemic placed an increased demand on NHS workers which required work patterns to change. I exhibit this Ministerial Advice at **M3VGE01/188 - INQ000116589**.

367. On 25 November 2020 I became aware in the Senedd that the recent Royal College of Nursing staff survey highlighted 34 per cent of staff—nurses, in particular—felt undervalued by the Welsh Government and 74 per cent of staff believed that they had seen an increase in their stress levels. I made enquiries and asked to see the report, which is exhibited at **M3VGE01/189 - INQ000328769**[7]. I did have regular engagement with the Royal College of Nursing but they had not chosen to speak to me about this report until its publication.

368. At the time of this report, the Chief Nursing Officer met with Executive Directors of nursing from across the NHS in Wales on a weekly basis around "hot issues". Workforce was a standing topic at these meetings, working together on challenges experienced with covering services. The wellbeing of the workforce was central to discussions when the Chief Nursing Officer visited with Local Health Boards or Trusts. The range of wellbeing offered to workforces, included a Samaritans listening support helpline, as well as several free-to access health and wellbeing support apps such as Mind, Sleepio & Daylight and SilverCloud.

369. In March 2021 the Welsh Government published "Health and Social Care in Wales-Covid-19: Looking Forward" which I exhibit at **M3VGE01/190 - INQ000066129.** This document identified workforce wellbeing as a challenge in the recovery from the Covid-19 pandemic and steps would be required to address it:

> *"Staff fatigue, particularly for those who have been on the front line over the last 12 months, is recognised as a major concern across all health and social care services. The recruitment and retention of staff is a challenge for all organisations. There is a need to deploy staff and other resources in a co-ordinated and effective manner.*

[7] This exhibit has been provided by another Material Provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the Public Inquiry [INQ000480721].

While it is important to support new initiatives and different ways of working to deliver effective health and social care in the future, the health and wellbeing of staff must be central if the system is to be sustainable"

370. I exhibit the integrated impact assessment for this recovery plan which noted that some groups of people were more vulnerable than others. Those who were more elderly and those that suffered with chronic conditions were more susceptible to Covid-19 and may have suffered more severe symptoms if they caught it. Some ethnicity groups were also more susceptible such as those from Black, Asian and Minority Ethnic communities. Both the framework and the guidance recognised this and required organisations to address these challenges in their plans **M3VGE01/191-INQ000469192**.

"Stay at home" messaging

371. I have been asked to comment on the extent to which we considered that public messaging of "stay at home, protect the NHS, save lives" or any other public messaging may have deterred patients in need of treatment for Covid-19 or other conditions from accessing healthcare.

372. We were conscious of the risk that some people might become over-cautious during the pandemic and that the "Stay at home" messaging might deter some from accessing healthcare they needed. However, there was a need to balance that risk with the very real need to protect the NHS. We were aware that if people did not reduce social interaction that there was a significant risk of direct Covid-19 harms. I took great effort during my sessions in Senedd and during press conferences to emphasise that essential services were still available for example cancer services and stroke care.

373. Further detail on the "Stay at home" messaging is included in M3-WGO-01 at paragraphs 656 to 662, including the way national messaging was updated to include symptoms that should prompt help-seeking behaviour, and the use of press conferences to build confidence in the NHS. We also relied on amplification by local partners such as NHS Wales bodies and local authorities to highlight the key messages to the public about how to safely access services in the NHS.

374. I believe now, as I did at the time, that our messaging struck the right balance.

Non-Covid-19 conditions

375. I have been asked to describe any information brought to my attention indicating a reduction in non-Covid-19 related healthcare during the pandemic, including details of how such data was monitored, what steps were taken to ensure that non-Covid-19 related healthcare remained available and how the Welsh Government ensured that this message was communicated to the public.

376. In April 2020, I received in informal briefing on (non-Covid-19) treatment waiting times, exhibited in **M3VGE01/192 – INQ000480715**. This stated that the end of March 2020 forecast was for there to be around 25,000 patients waiting over 36 weeks, around 16,000 higher than the March 2019 position and that, with the announcement of the suspension of non-urgent elective activity due to coronavirus, this was expected to increase further over the next two weeks as Health Board's cleared capacity for the expected influx of Covid-19 patients.

377. On 21 April 2020 I received an informal briefing on cancer performance across Local Health Boards, exhibited in **M3VGE01/193 – INQ000480717**. Health Boards variously reported the expectation of a drastic decrease in performance in March and April, significant risk to the delivery of cancer waiting times targets due to service disruption as resources were drawn on to support management of the pandemic and a loss of staff to infection or self-isolation, and the development of priority plans for cancer patients.

378. Also in April 2020, I received an informal briefing on unscheduled care activity and performance, exhibited in **M3VGE01/194 – INQ000480716**. This noted that there were 16,544 ambulance arrivals at emergency departments in March 2020, 1,902 fewer than February 2020. It also included the following table on emergency department attendances, showing a drop in March 2020 on previous years:

March	2016	2017	2018	2019	2020
Attendances	87,470	86,351	83,561	89,299	63,153
# patients admitted / discharged in 4 hours	66,880	69,927	63,221	70,301	49,154
4 hour performance (%)	76.5%	81%	75.7%	78.7%	77.8%
>12 hour performance	4,393	3,191	5,443	4,469	3,291

379. From April 2020 I received briefing notes on NHS activity every 2 months, I exhibit an example at **M3VGE01/195 – INQ000480713**.

380. On 23 April 2020, the Welsh Government published a summary of activity data, including the latest available monthly information on A&E attendances, emergency calls to the ambulance service and patients starting cancer treatment. This is exhibited in **M3VGE01/196 – INQ000480736**. The accompanying announcement, exhibited in **M3VGE01/197 – INQ000480735** noted that, following the announcement on 13 March 2020 regarding the cancellation of certain medical procedures and the relaxation of performance targets, several national data collections had been temporarily ceased in Wales. This meant that, until at least October 2020, published NHS performance data would include information on A&E attendances and admissions, emergency calls to the ambulance services and patients starting cancer treatment, but would not include performance related information or information relating to referral to treatment times, diagnostic and therapy waiting times, delayed transfers of care, closed pathways or outpatient referrals.

381. 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" I approved investment of £100m 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 I received, dated 19 March 2021, is exhibited at **M3VGE01/198 - INQ000116613**.

382. On 19 November 2020, I made a statement, exhibited in **M3VGE01/199 - INQ000480727** regarding the resumption of publication of NHS performance measures, following the pausing of some routine activities on 13 March 2020. This noted that hospitals had to transform the way they operated to keep staff and people safe and to prevent the spread of the virus, which had a major impact on capacity, activity and waiting times. In particular, I stated that:

a) "As expected, we have seen a significant rise in waiting times for elective treatment. Operating with new social distancing restrictions, strict infection control and other measures to keep people safe, mean the NHS is only able to carry out about half the number of procedures every day, compared to pre-pandemic levels."

b) "The Welsh Ambulance Service has reported its response times have been impacted by the additional time it takes for paramedics to put on the required level of PPE, as well as the need to deep clean vehicles after call outs."

c) "While in the early part of lockdown our Emergency Departments saw a fall in the usual footfall, demand has begun to return to normal levels at a time when they are now operating with reduced capacity due to infection control and physical distancing requirements."

d) "In anticipation of a challenging winter period, we have made an additional £30m funding available to support urgent and emergency care services and increase resilience over the remainder of 2020/21. All our health boards now have plans in place to operate under these new circumstances and to see patients in order of clinical priority. However just as in other UK nations it will take a long time to return to the position we were in before the pandemic. That will require significant resources over and above the current funding to respond to the unfinished pandemic."

383. Data relating to non-Covid-19 healthcare and details of the steps taken by the Welsh Government to maintain non-Covid-19 care and treatment throughout the pandemic are set out at length in the Module 3 witness statements of Dr Goodall (reference M3-WGO-01) and Judith Paget (reference M3-WGO-02), including reference to the Welsh Government's Winter Protection Plan 2020/21, the 'Health and

Social Care in Wales COVID-19: Looking Forward' publication and the 'Programme to transform planned care and reduce waiting times'.

384. As I have noted earlier in this statement, Dr Goodall's Module 3 statement also describes the steps taken by the Welsh Government to ensure that the message was communicated to the public that non-Covid-19 healthcare remained available throughout the pandemic.

385. I met with the Wales Cancer Alliance on 25 June 2020 to discuss the effect of the pandemic on cancer services. I wrote to the chair of the Wales Cancer Alliance on 4 August 2020 summarising the meeting and addressing a number of individual queries raised by members of the Alliance. I noted that the Welsh Government had worked closely with the Wales Cancer Network to develop expert guidance on the maintenance and recovery of cancer services during the pandemic, which was used to plan cancer services through the quarterly planning framework. I also stated that referral activity was recovering and screening services were restarting, and that the NHS in Wales needed to plan for a potential increase in cancer demand as a result of delayed presentations and treatment.

386. I met with the Wales Cancer Alliance again on 25 February 2021 to discuss the recovery of cancer services, the planned move to the single cancer pathway, and the development of a replacement for the Cancer Delivery Plan. The introduction of the single cancer pathway is explained in greater detail in Judith Paget's witness statement to the Inquiry (reference M3-WGO-02). On 16 March 2021, I wrote to the Alliance's chair summarising our 25 February meeting and again addressing some queries.

387. These included a query as to why the Welsh Government was not publishing a cancer-specific recovery plan. I responded that cancer care relied on referral by primary care, access to multiple diagnostic modalities, access to outpatient clinics and emergency departments, and for many patients - access to surgical services. Therefore, the recovery of cancer services could not be planned in isolation and had to be part of a broader plan for recovery of all these parts of the NHS. I highlighted that this broader approach to NHS recovery was in development and would have a focus

on cancer pathways and would likely make use of the national implementation group and network to lead any cancer specific national actions.

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: 15th July 2024