IN THE UK COVID-19 PUBLIC INQUIRY
CHAIR: BARONESS HEATHER HALLETT

On behalf of the Wales TUC
Adam Morgan Statement
First Witness Statement in Module 3
Dated: 22 January 2024

WITNESS STATEMENT OF ADAM MORGAN

I, Adam Morgan, on behalf of the Wales Trades Union Congress ("Wales TUC"), will say as follows:

1. This statement is made for the purposes of Module 3 of the Inquiry, which is examining the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland.

2. This statement is structured as follows:
   (A) Introduction;
   (B) The Wales TUC, and structures for liaison with the Welsh Government;
   (C) Pre-pandemic state of the healthcare system across Wales;
   (D) Impacts of the pandemic upon healthcare staff in Wales;
   (E) Infection prevention and control;
   (F) Health and Safety Executive;
   (G) Investigation and reporting of workplace deaths;
   (H) Long Covid; and
   (I) Conclusion and recommendations.

(A) INTRODUCTION

3. The Wales TUC is part of the Trades Union Congress ("TUC") and serves the interests of the TUC's 48 affiliated unions in Wales. It represents around 400,000 workers in Wales and seeks to be the voice of Wales at work. The Wales TUC campaigns for a fair deal at work and for social justice at home and abroad. A number of the affiliated unions represent workers across the whole range of roles in the healthcare professions, from doctors, nurses and paramedics, to porters and physiotherapists. In practice, it was the unions representing health workers who took the lead role in engaging with NHS Employers and the Welsh Government on these matters through the Business Committee (see below). Most of these health unions are members of the Wales TUC.

4. I am the Senior Negotiating Officer for the Chartered Society of Physiotherapy (CSP) and I have been since before the pandemic. I act as the full-time trade union official supporting, training and advising the network of the CSP's workplace stewards and health and safety reps. I liaised and negotiated on behalf of the CSP with Welsh Government and NHS Employers to ensure our members were being represented and also acted as a conduit for information coming from Welsh Government and NHS Wales employers to our representative networks and subsequently our membership. I was part of the Welsh partnership forum and the executive, the business committee, of the Welsh partnership forum and thus was directly engaged in discussions about the health, safety and wellbeing of the NHS workforce and what we could do to protect them. I was also nominated by the business committee to sit on the nosocomial transmission group, which was a Welsh Government meeting set up to look at managing the spread of coronavirus in hospitals. I am a member of the Wales TUC's General Council.

5. It would be remiss of me to not give due attention to the bravery and dedication of health workers during the peak of the pandemic. The courage and dedication to patients despite fears for both their and their family's safety must be recognised.

6. There is not one occupation that stands out for special mention above another. Every occupation, every worker contributed, in such a manner that was beyond a call of duty that many will ever experience.

7. However, this is not without consequence. In the process of obtaining evidence for this Inquiry, we are reminded – via the anecdotes and memories of members – of decisions made and conversations had during the pandemic that will forever stay with them. Members told us of conversations with families, informing them that their loved ones, in need of care, could not receive it and that other patients were being prioritised due to a greater likelihood of a positive outcome. We heard stories of workers taking the decision to move into temporary accommodation, on-site, to minimise the risk to their family and friends, thereby simultaneously shouldering the twin burdens of guilt and fear, in isolation.

8. The long-term effects on individuals, will vary, however, it is reasonable to ascertain that not one worker will have remained unchanged after the experience. Governmental decisions post-pandemic related to pay, terms and conditions have indicated to health workers that the rhetoric and gestures which were in such abundance during the pandemic are just that, and of no substance. It is yet another factor to be considered in addressing the retention of health workers.

9. This statement addresses the role played by trade unions, through social partnership, in influencing Welsh Government and NHS Wales decisions regarding the workforce. This is in relation to issues such as PPE, testing, Long Covid and other matters. I also highlight the impact of Covid on healthcare workers from a Black, Asian and Minority Ethnic background and some of the steps taken to support them.

(B) THE WALES TUC, AND STRUCTURES FOR LIAISON WITH WELSH GOVERNMENT

10. The TUC brings together over 5 million working people that make up its 48 members unions, from all parts of the UK.

11. The Wales TUC is part of the TUC and sits within the TUC's Organisational Services and Skills Department. It is an integral part of the wider organisation but autonomous in some policy areas. It represents around 400,000 workers in Wales through its affiliated unions. The Wales TUC exists to improve the economic and social conditions of workers in Wales.

12. The Wales TUC has devolved responsibility within the TUC for:

    a. matters which are within the powers of the Welsh Government and the Senedd;
    b. matters that are wholly specific to Wales; and
    c. developing policy on matters which impact substantially differently on Wales than elsewhere in the UK.

13. The Wales TUC consists of trade unions that are affiliated to the TUC and who have members in Wales and trades union councils in Wales registered with the Wales TUC. I exhibit a list of affiliated trade unions [Exhibit AM/1 - INQ000068440].

Wales TUC's role in relation to workers in the pandemic

14. The general role of the Wales TUC consists of the following:
    a. to promote the interests of all or any of its member organisations or the interests of past and present individual members of such organisations living or working in Wales:
    b. to improve the economic, equality and social conditions of workers in Wales, whether or not such workers are employed or have ceased to be employed;
    c. to give effect to the policies of Welsh Congress and to give effect in Wales to the policies adopted by the TUC and to keep trade union members in Wales informed of those policies;
    d. to co-operate with and assist other organisations having similar objects to the Wales TUC; and
    e. to assist in the complete organisation of all workers in Wales eligible for membership of its member organisations.

Summary of advisory bodies with which Wales TUC worked during the pandemic

15. An important point of context to the Wales TUC's liaison and communication with the Welsh Government is the approach in Wales to social partnership. Social partnership refers to a form of partnership working between employers and workers (through their representative organisations such as trade unions) and the government. It encourages collaboration in the delivering of public services and is intended to be a means of promoting economic growth and improvements in well-being. As the Welsh Government has described it, it *"brings together government, employers and trade unions in areas of mutual interest, to design and implement better solutions."* [Exhibit AM/2 - INQ000180903].

16. Social partnership is part of an approach in Wales which has recognised the value and importance of trade unions, including the importance of collective bargaining in reducing inequality and resulting, ultimately, in a fairer and more prosperous economy. Consistent with the recognition in Wales of the value of trade unions, certain provisions of the Trade Union Act 2016 introduced by the UK Government and which imposed restrictions in relation to trade union membership and action were curtailed in Wales by the Trade Union (Wales) Act 2017. An evidence-based study of the value of trade unions in Wales was published in October 2019 by the Wales Centre for Public Policy [Exhibit AM/3 - INQ000180904].

17. Social partnership was central to the approach of the Welsh Government throughout the pandemic. Before the onset of the pandemic the approach to social partnership was well established, and the Government was considering putting it on a more formal and structured footing. On 7 November 2019 Julie James AM, Minister for Housing and Local Government, published a White Paper seeking views on the Social Partnership Bill [**Exhibit AM/2** - INQ000180903]. In the event, the timetable for the Bill was elongated by the pandemic and it was only on 24 May 2023 that the Welsh Parliament passed the Social Partnership and Public Procurement (Wales) Act 2023. The Act in its entirety is relevant to decisions relating to the healthcare system. Part 1 established a Social Partnership Council, comprising members of the Welsh Government, nine representatives of employers, and nine representatives of workers in Wales nominated by the Wales TUC, which will provide advice to Ministers on how

public bodies, including health boards, are working in partnership with trade unions in their decision making. Part 2 places a duty on public bodies in Wales, including health boards, to work in social partnership – that is, to include trade unions in their decision making. Part three reforms public procurement, which includes health boards.

NHS Welsh Partnership Forum Business Committee

18. The NHS Welsh Partnership Forum (WPF) has been established as the forum where the Welsh Government, NHS Wales's employers and trade unions and professional organisations work together to improve health services for the staff and the people of Wales. It is the forum where key stakeholders can engage with key policy leads from across the Welsh Government to inform thinking around national priorities on health issues.

19. The WPF is supported by a Business Committee (WPFBC) and the Medical and Dental Business Group (MDBG) established to oversee the business of the WPF and manage the range of workforce issues that require more detailed work. The WPFBC (also referred to as the 'Business Committee') operates as an executive for the WPF. It played a critical role during the pandemic.

20. The main purpose of the WPF is the development, support and delivery of workforce policies on a national, regional and local level. The Welsh Partnership Forum provides strategy leadership on partnership working between employers and employee representatives.

21. The principle focusses and purposes of the WPF are:

    a. Service change and modernisation – to redesign services to be modernised in line with the aims within A Healthier Wales.
    b. Service Delivery – influencing, developing and engaging in the formulation of national strategies to ensure they are deliverable and have ownership.
    c. Workforce – taking a national overview on issues regarding the workforce.

22. It is also involved in all aspects of strategic implementation including [Exhibit AM/5 – INQ000339501]:

    a. planning
    b. education
    c. recruitment
    d. retention
    e. development; and
    f. support of NHS Wales staff.

23. Unfortunately, I do not have formal minutes of these meetings, but the Wales NHS Federation may be able to provide these. Instead, I exhibit notes of Business Committee meetings on 26 March 2020 [Exhibit AM/6 – INQ000339502]; [Exhibit AM/7 – INQ000339503]; [Exhibit AM/8 – INQ000339504], at which the most important points of discussion concerned PPE, pregnant workers and communication, and 7 October 2020 [Exhibit AM/9 – INQ000339505], where the key points related to mental health and well-being services and a review of advice for shielding of vulnerable people.

The Workforce Partnership Council

24. One of the forums for social partnership that existed throughout the pandemic was Workforce Partnership Council (the "WPC"). It is a tripartite social partnership structure of the trade unions, employers and Welsh Government covering the devolved public services in Wales. The WPC is supported by a Joint Executive Committee (JEC) comprising members of each of the three social partners of the WPC. Minutes of the meetings of the WPC and JEC are made publicly available.

25. The WPC meetings provided regular opportunities for union representatives, employer representatives, and members of the Welsh Government to discuss pressing concerns and developments. Government representatives were able to provide updates as to Government policy, and the unions were able to feedback concerns.

Shadow Social Partnership Council

26. The first iteration of the Shadow Social Partnership Council was established in late 2019, in anticipation of the Social Partnership Council which was created after the pandemic. A draft Terms of Reference was produced for the meeting on 23 March 2020 [Exhibit AM/10 - INQ000068443] and the Welsh Government proposed to expand the membership on 1 May 2020 [Exhibit AM/11 - INQ000068444]. A definitive list of members was not shared, but the meeting minutes provide a good indication of who would typically attend [Exhibit AM/12 - INQ000068445].

27. During the meeting of the SSPC on 14 May 2020 it was agreed that membership should be extended on a temporary basis due to the exceptional circumstances presented by the pandemic [Exhibit AM/13 - INQ000180855], and the First Minister convened fortnightly meetings of the SSPC.

28. The meetings typically took the form of an update from the First Minister on the Covid-19 situation in Wales, and then two further updates (usually from other Ministers or the Chief Medical Officer) about the Welsh Government's response to the pandemic, including updates on the vaccination programme and briefings about Cabinet's direction ahead of the coronavirus press conferences.

Regular briefings

29. Early in the pandemic an arrangement was agreed for the Wales TUC to provide regular briefing documents summarising for the Welsh Government the key and current issues being raised by the range of unions. I provide the briefing notes in my possession, dated 18 March 2020 [Exhibit AM/14 - INQ000068452], 27 March 2020 [Exhibit AM/15 - INQ000068454] and 3 April 2020 [Exhibit AM/16 - INQ000068455]. They were sent to Jo Salway (Director, Social Partnership and Fair Work) and Jane Runeckles (Special Advisor to the First Minister). The purpose was to provide a top-line summary of the most pressing issues. The 18 March note briefed that the NHS staff council in England had agreed guidance and measures for dealing with Covid-19 for all NHS Trusts, which included assessing which employees would be most at risk should there be confirmed cases. The 27 March update highlighted concerns about

the lack of testing for healthcare workers, and the 3 April note raised the issues of availability of PPE and testing for key groups of workers.

First Minister's Black, Asian, Minority Ethnic Covid-19 Advisory Group

30. The BAME Covid-19 Advisory Group was convened to advise the First Minister on the disproportionate impact of Covid-19 on some ethnic groups. The group worked with stakeholders from BAME communities, experts within Wales and across the UK (especially PHE), and international colleagues to share information and approaches to address this issue. At a meeting on 10 June, the group discussed the operation of a new BAME risk assessment in the NHS, which had been developed by a sub-group. The minutes note the risk assessment tool appeared to have been well-received and was effective at measuring the perceived risk, although whether it was responsible for a reported decrease in the number of deaths in healthcare workers was unknown [Exhibit AM/65 - INQ000397200]. The socio-economic sub-group published a report in June 2020 which made recommendations in relation to the health workforce [Exhibit AM/66 - INQ000227599]. These recommendations included: taking immediate action to improve the quality of recording of ethnicity data; ensuring wide dissemination of the risk assessment tool backed by robust employer and employee advice; and addressing any unfair or illegal discrimination at work in, or by users of, NHS Wales.

(C) THE PRE-PANDEMIC STATE OF HEALTHCARE SYSTEMS ACROSS WALES

31. The NHS was unprepared for a health event on the scale of the pandemic.

32. In the years leading up to the pandemic, the NHS in Wales, like the NHS in the rest of the UK, had consistently high rates of job vacancy Those rates persisted despite repeated attempts to improve recruitment and retention. As a result, in March 2020 staff had already worked through years of unrelenting strain.

33. The pandemic brought existing staffing problems to breaking point. One strategy used to staff hospitals in Wales was to require allied health professionals to step into nursing roles. Health students were permitted to pause their studies and temporarily join the workforce. Although most of those students have now completed their studies and

moved into full-time work, it remains the case that the demand for labour far exceeds supply.

34. NHS Wales was facing financial difficulties for many years leading up to the pandemic. In 2016, the Health Foundation published a report which recommended that to ensure long-term sustainability of the service, policymakers and NHS leaders in Wales needed to take sustained action to secure its long-term future [Exhibit AM/67 - INQ000400165]. The report went on to detail what would be required, including:

    a. increasing funding by at least 2.2% each year from 2019/20 until 2030/31;
    b. developing a strong workforce policy that ensures adequate numbers of high quality and motivated staff are retained and recruited, despite continued pay restraint;
    c. investing adequately in a range of public services, particularly social care; and
    d. continuing to make efficiencies and reform health care to meet the population's changing and growing needs.

35. On the eve of the pandemic, in January 2020, the then National Assembly's Health and Social Care Committee reported that NHS Wales was facing financial difficulties and performance challenges across a number of health boards [Exhibit AM/68 - INQ000400166]. The report stated that only three health boards were meeting both statutory financial duties (to achieve financial balance and to have an approved three year integrated medium term plan), which raised serious questions about how all health boards would be able to invest in and secure service transformation, given that specific transformation funding was to end in 2021. The Committee was further concerned that four health boards were subject to escalation and intervention arrangements, with Betsi Cadwaladr having been in special measures since 2015.

36. I do not have further information relating to the critical care capacity within the NHS, NHS buildings, equipment and technology or other aspects of the capacity or preparedness of the Welsh healthcare system prior to March 2020. However, it is clear that due to underfunding over many years, the service was facing many challenges, including the ability to recruit and retain staff.

(D) IMPACTS OF THE PANDEMIC UPON HEALTHCARE STAFF IN WALES

The mental health and wellbeing of healthcare staff

37. Early in the pandemic, unions took note of a prevailing sense of camaraderie amongst healthcare workers. As the outbreak progressed, however, healthcare workers experienced growing levels of burnout, fear, confusion, uncertainty, and anxiety.

38. By the Autumn of 2020, burnout amongst healthcare staff had become widespread and difficult to manage. As restrictions eased, politicians and NHS employers shifted their focus from treating Covid-19 patients to addressing the backlog of scheduled care issues that had accumulated. Instead of taking a break, healthcare staff maintained their intense workload to alleviate the pressures that had built up during the height of the pandemic. They never had a period of downtime in which they could rest, recover and process their experiences during the months of the pandemic. As a result, burnout has continued and will leave a legacy that affects staff for years into the future My notes of the 7 October 2020 meeting of the Business Committee of the NHS' Welsh Partnership Forum refer to discussions regarding staff well-being and that staff were exhausted, with a well-being group being established to help tackle the issue [Exhibit AM/9 - INQ000339505]. Emails from the Royal College of Nursing show that there was still a need to raise awareness of the Staff Well-Being Support Service in July 2021 [Exhibit AM/17 - INQ000339506].

39. Many healthcare workers also experienced a heightened fear of infection, particularly in the early days of the pandemic. This was aggravated by the lack of available PPE (as discussed in paragraphs 77 to 92 below). Ambulance workers were particularly distressed by having to wait outside hospitals for long periods of time with infectious patients. Often, that wait followed a period of time at the patient's home. Pregnant staff were given mixed messages about their safety at work and the Royal College of Obstetricians and Gynaecologists (RCOG) guidance changed repeatedly, causing confusion and stress. Workers also experienced uncertainty created by changing guidelines about vaccine doses: workers reported particular concern about the decision to change the waiting period for a second dose from 28 days to 12 weeks.

40. The workplace pressures placed on healthcare staff must be understood in light of the fact that staff were simultaneously dealing with the same personal grief and loss as the rest of the population. Healthcare workers who had to shield felt lonely, isolated, and fearful during the pandemic, and their health conditions often worsened. In some cases, personal and workplace stresses compounded one another. For example, members told UNISON about having to explain to loved ones that they could not access medical care because patients with better chances of recovery were being prioritised. I have not been able to obtain any further detail on this in the time available, but, if the Inquiry wishes, I can make enquiries and provide a supplementary statement if necessary.

41. Some workers moved into temporary accommodation to minimise the risk of infection to their family and friends, leaving them to deal with burnout and work stress in isolation. Some of the stress borne by healthcare workers would have been avoided with better communication and oversight. For example, healthcare staff found out about changes to infection, prevention and control restrictions at the same time as the general public, making it difficult for workers to plan ahead. However, I acknowledge that it may have been difficult to provide information any sooner, such was the pressure on decision-making. Similarly, midwives and nurses faced anxiety after the regulator, the Nursing and Midwifery Council (NMC) accepted that patient care on maternity wards would be inevitably poorer during the pandemic but did not change the official standards. Staff were concerned by the prospect of facing "fitness to practice" (FtP) hearings where standards were not met with no guarantee of leniency. That is, staff were concerned that a complaint could be made against them which led to a hearing before the NMC to decide whether they were fit to practice in their role and being struck off. This would be despite the fact workforce regulators had acknowledged that Covid restrictions meant that care quality would be lower during the pandemic, as can be seen in the joint statements issued by the NMC, the Health and Care Professions Council (HCPC) accepting that the quality of patient care and that that the circumstances of the pandemic would be accounted for in any FtP hearing, did little to assuage concerns [Exhibit AM/18 - INQ000339507]; [Exhibit AM/19 - INQ000339508].

42. On 3 April 2020, the Wales TUC wrote to the Welsh government calling for greater transparency and consultation in decision making. The Wales TUC said: "*There needs to be* clear *direction from Welsh Government that decisions on this need to be taken in social partnership... Some unions feel that health boards are reverting back to a command and control approach. There are particular concerns raised by allied health professional unions that their members were being treated poorly, facing significant changes with no voice in some circumstances.*" [**Exhibit AM/16** - INQ000068455]. The Wales TUC does not have a record of receiving a response to this letter.

Mental health and wellbeing on ethnic and other minority healthcare workers

43. From the start of the pandemic, unions reported that BAME workers were being discriminated against in a number of ways, including being singled out for more dangerous or difficult work, having inadequate access to PPE, not being protected despite having underlying health conditions, being targeted when hours or jobs were being cut, and being racially abused by colleagues or customers [Exhibit AM/21 - **INQ000119179** [Exhibit AM/22 – **INQ000271386** Unsurprisingly, these patterns presented particular problems in healthcare contexts.

44. On 21 April 2020, the Wales TUC circulated a report titled *Equality Impacts of Covid-19* [Exhibit AM/23 - INQ000339510]. The report made an urgent call for the ongoing collection of data aggregated by ethnicity and noted that to that date, 100% of doctors who had died of Covid-19 were from BAME backgrounds. The Wales TUC observed that a narrative was forming that BAME people were simply "more affected" by medical problems, a matter "not yet proven".

45. On 23 April 2020, UNISON Cymru called for an investigation into the acute impact of Covid-19 on Black workers [Exhibit AM/24 - INQ000339511]. It made three specific demands of the NHS:
    a. to identify what workforce data should be collected to better understand the impact of covid on Black staff;
    b. to identify how organisations could make sure that their actions in deploying or redeploying staff to covid duties did not contribute to a disproportionate impact on healthcare workers from Black backgrounds; and

c. to ensure tailoring and uptake of health and wellbeing and psychological support services by Black staff.

46. Partly in response to UNISON's concerns and similar concerns raised by Wales TUC and organisations representing Black, Asian and Minority Ethnic (BAME) workers and with the support of the Welsh Government on7 September 2020, the Ethnic Minorities and Youth Support Team (EYST) launched a BAME helpline with Wales TUC's support [Exhibit AM/25 - INQ000339512]; [Exhibit AM/26 - INQ000339513]. The severe impact of Covid-19 on BAME healthcare workers was compounded by existing workplace inequality. In December 2020, UNISON Cymru reported the findings of a survey of Black members (across all sectors, not just healthcare) in Wales. It found that 44% of respondents did not feel comfortable reporting their safety concerns. 37% reported that their employer had not conducted a formal risk assessment [Exhibit AM/27 - INQ000339514]. In reporting the results, the chair of UNISON Black members, Kebba Manneh, described black workers in the NHS facing racial abuse. He also said that "We can't be blind to the structural racism that also exists. A majority of Black healthcare workers feel the colour of their skin has held their career back and most of those experiencing racism didn't feel it was worth reporting it to their manager. Almost half have not felt comfortable reporting their safety concerns during the Covid pandemic, despite the virus' clear disproportionate effect on Black people." He called on Health Boards to *"do more to ensure Black healthcare workers are better valued and supported"*, and to *"address the lack of Black people in senior leadership positions in NHS Wales … so the health service better reflects the society it serves."*

47. Recruiting from overseas requires significant resource if it is to be accomplished ethically, securely, and successfully. UNISON has worked with extensively with employers to assist in helping migrant workers settle in the UK. However, it is still the case that many overseas workers who arrive in the UK intending to work in the NHS upon completing the necessary requirements such as the Objective Structured Clinical Examination do not successfully join the NMC register. As a result, individuals seek work in the social care sector and, in too many incidences, are treated with no dignity and often subject to working conditions worse than domestic staff.

Mental health and wellbeing of women

48. Women working in healthcare also experienced specific, and in some cases more acute, emotional, physical and fiscal challenges throughout the pandemic. UNISON conducted a survey of women workers in February 2021 about the pressures they faced. The survey found that half of respondents (50%) didn't have time for themselves to reflect and de-stress – for women with children and/or vulnerable adults at home this rises to more than three in five (62%).

49. More than two in five (46%) of respondents said they have not been exercising regularly during the pandemic. Almost two thirds (65%) say they haven't been sleeping well at night [Exhibit AM/28 - INQ000339515].

The role of unions in monitoring and supporting mental health and wellbeing

50. Unions struggled to consistently monitor the mental health and wellbeing of healthcare workers, particularly in the early days of the emergency response. The nature of the crisis meant there was little time to do this. Whilst unions recognise that the primary duty of care for the wellbeing of staff is the employer (for example, through occupational health and staff surveys), there are instances where a union will explore the mental health of members, both individually or collectively, usually as a matter of course during individual representations or in workplaces with systemic long-term issues. In the normal course of events, union branches could monitor the mental health of their members informally, through talking with people when they attended face-to-face branch meetings. The pandemic meant that the priority of trade unions branches was to safeguard the physical safety of their members by pressing managers for safe and secure PPE and compliance with Covid safety regulations. Monitoring members' mental health became harder as branch meetings switched to video conferencing. Some larger unions have conducted regular surveys of their members' mental health at an all-Wales and British level, but this was not possible during the height of the pandemic. The monitoring efforts that were put into effect later in the pandemic paint a dark picture. On 10 May 2021 UNISON Cymru published a membership-wide survey of healthcare workers and found that 48% were struggling to cope [Exhibit AM29 - INQ000339516].

51. The Wales TUC and its member unions provided a range of support tools to support workers' mental health and wellbeing. For example:
    a. Union stewards and health and safety representatives were appointed to provide advice, guidance and reassurance to healthcare workers. Because they were often the first to know about changes to restrictions and rules, they alleviated fear by ensuring that workers were updated on appropriate safety practices;
    b. Wales TUC supported the launch of a BAME helpline operated by EYST (see above);
    c. Some member unions produced guidance to aid branches in their discussions about workers' conditions with employers;
    d. UNISON Cymru worked with the Welsh government and NHS Workforce and Organisation Development Directors to develop consistent messaging about employers' duties to monitor and enact measures to address staff mental health;
    e. UNISON Cymru partnered with the mental health charity MIND to deliver free courses to promote "active monitoring" of mental health and to help understand and manage PTSD [Exhibit AM/30 - INQ000339517]. The courses had significant uptake [Exhibit AM/31 - INQ000339518]; and
    f. The CSP worked with the Welsh Government and NHS Employers to produce, in partnership, a Workforce Wellbeing Conversation tool that was implemented in the NHS and Social Care Sector. This was a guide for managers to discuss the wellbeing of their staff on a one-to-one basis.

52. Despite their efforts, the measures unions were able to take to assist health workers with their overall mental health were dwarfed by the scale of the issues.

Absences

53. Personnel absences had a serious impact on the physical and mental wellbeing of healthcare staff, the overall quality of care provided to patients, and patient safety.

54. Healthcare workers in some contexts experienced continuous redeployment to cover those isolating with Covid-19. Some staff were subjected to disciplinary action if they refused redeployment, a threat that added to existing pressures that they faced. In

response, a branch in one Health Board introduced a program called "Refusal to Move", in which local union members intervened to ensure that workers who refused redeployment were protected from punitive action.

55. In some contexts allied healthcare workers, such as physiotherapists, were expected to step outside their expertise to fill absences in nursing and support staff. Members of the CSP felt that their role in the management of patients was undermined and undervalued, as whilst it was in pandemic response mode, those individuals still had physiotherapy needs and whilst they were redeployed to carry out nursing roles, those physiotherapy needs went unmet and caused longer term issues for the patients, as can be seen in CSP member WhatsApp messages from March 2020 [Exhibit AM/32 - INQ000339519]; [Exhibit AM/33 - INQ000339520]; [Exhibit AM/34 - INQ000339521]; [Exhibit AM/35 - INQ000339522]; [Exhibit AM/36 - INQ000339523]; and an email to me from a CSP member in October 2021 regarding physiotherapists being asked to carry out nursing shifts [Exhibit AM/37 - INQ000339524].

56. Some employers responded to increased staff absences by cancelling annual leave or introducing policies whereby health workers could "sell" their leave back to their employer or carry it into the following year. The latter policy created a backlog that was impossible to clear without the introduction of a deadline for use, after which workers would lose their accumulated leave.

57. Difficulties arose in relation to employers who did not properly accommodate workers who were shielding for their own health or to care for someone else who was clinically vulnerable. Initial confusion about who should isolate was later clarified by a set of guidelines published by the Welsh government. Even after the guidelines were issued, however, there were still cases where Health Boards informed workers who were caring for others that they would need to take unpaid leave or other forms of leave. In one case, a member was told that she would need to take a career break to look after a child who had to shield [Exhibit AM/38 - INQ000339525]. In another, an employer deducted 8 days' annual leave from a shielding worker [Exhibit AM/39 - INQ000339526], a decision which UNISON Cymru/Wales successfully challenged [Exhibit AM/40 - INQ000339527].

58. Key healthcare workers also lacked access to childcare, a matter that was raised at Business Committee Meetings and meetings with the Minister, Vaughan Gething [Exhibit AM/41 - INQ000339528]; [Exhibit AM/42 - INQ000339529]; [Exhibit AM/43 - INQ000339531]; [Exhibit AM/44 - INQ000339532]; [Exhibit AM/45 - INQ000339533]. There seemed to be a gap of responsibility, the Welsh Government advised that it was for local authorities to provide the childcare, rather than the NHS. But this meant very patchy access across Wales, as each council had different processes and criteria to access support.

59. Staff absences had predictable effects on patients: UNISON Cymru reported that many members felt that they could not deliver the necessary level of patient care.

Working from home

60. The NHS pivoted to virtual consultations soon after the outbreak of the pandemic, allowing at least parts of the workforce to work from home.

61. However, some workers could not work from home. This created inequality in how workers managed obligations caring for children and vulnerable relatives or recovering from Covid-19. Often, it was workers in more senior positions who were able to work from home and thus manage illness or caring for others, while staff in lower positions were required to take leave to deal with the same problems.

62. Although it was well understood that people in some roles simply could not work from home, there was still division and resentment created, particularly where it appeared that manages were benefiting from homeworking. For example, Unite members noted that managers would sometimes leave meetings early to collect children from school, something that front line staff could not do. Conversely, anecdotes emerged of some managers remaining on site where they would have been more beneficial working from home.

63. Additionally, not all health workers who were permitted to work from home were able to do so. Issues arose around access to suitable IT, such as laptops. There was no systematic effort to ensure that workers had the equipment that they needed to work

from home, with the result that individual managers were left to arrange access. Union members reported that presenteeism affected how equipment was provided.

NHS buildings

64. Social distancing requirements made space a valuable asset. The need for more space for emergency and urgent care led to 22 physiotherapy and rehabilitation spaces in Wales being lost to other services.

65. While this was an understandable decision, removing rehabilitation and physiotherapy spaces was on the whole counterproductive. Continuing to ensure good quality rehabilitation would have allowed patients to recover more quickly and reduced the length of their stay.

66. CSP members, stewards and representatives fought the appropriation of rehabilitation spaces. On two occasions, CSP wrote to Chief Executives to emphasise the importance of preserving rehabilitation spaces. The Health Minister issued a verbal statement highlighting the importance of rehabilitation space. However, no firm plans were made to return the spaces, an issue that persists today.

Recruitment

67. The Welsh government recently published a "National Workforce Implementation Plan", which signals that overseas recruitment will be critical to resolving the staffing crisis. This is tacit acknowledgement that, so far, Wales, like the rest of the UK, has not been able to find a long-term solution to the recruitment and retention problems in the NHS.

Long Covid

68. In April 2022, UNISON published a survey of health workers [Exhibit AM/46 - INQ000339534] in which 1,900 respondents - including healthcare assistants, nurses, porters, and clinical support staff - reported experiencing or having recovered from long covid. 68% of those respondents felt pressure to return to work early because they were afraid of losing their jobs, meaning that they were working while suffering

from symptoms such as breathlessness, fatigue, brain fog and aching joints. 8% of those surveyed were so sick that they could not go back to work at all. 40% reported that their employers had been initially supportive, but that the support had waned as time had passed.

69. Extended sick pay was agreed right at the start of the pandemic for workers suffering from Covid. Unions played an important role in negotiating with Welsh Government and NHS employers to support sufferers. Later this was extended to include 12 months' full pay to workers suffering from long covid, with longer periods for those who contracted Covid-19 earlier in the pandemic [Exhibit AM/47 - INQ000339535]; [Exhibit AM/48 - INQ000339536]; [Exhibit AM/49 - INQ000339537]; [Exhibit AM/50 - INQ000339538].

70. As the pandemic progressed, NHS employers sought on several occasions to remove long covid sufferers' entitlement to sick leave with full pay. Unions negotiated two extensions of full pay entitlements and then, once the pandemic was defined as endemic, transitional arrangements. Those transitional arrangements included the discretionary extension of full pay entitlements and grants of temporary injury allowance where employers had caught Covid-19 at work. There was particular resistance to the latter proposal within certain Health Boards. Unions also worked with NHS employers to develop guidance to assist employers of Long Covid sufferers with absence management, capability policies and/or reasonable adjustments [Exhibit AM/51 - INQ000339540].

71. In 2021 some health boards expanded their well-being offer. In September 2021, the Welsh Government set up the *Adferiad* programme to support healthcare staff [Exhibit AM/52 - INQ000339541]; [Exhibit AM/53 - INQ000339542]. Under this programme, the Welsh Government allocated £5 million in June 2021 to the seven Local Health Boards for the introduction of a suite of patient pathways combined with new or expanded primary and community rehabilitation services to support people with Long Covid. The programme was open to both the public and healthcare staff and offered community-based, integrated and multi-professional rehabilitation services.

Impact and partnership working with the Welsh Government

72. The wilful participation of the Welsh Government in engaging with trade unions helped to both identify and implement actions identified through monitoring efforts. At a national level, the degree of partnership working between trade unions, employers and Welsh government during the pandemic was without precedent in the health service in Wales and it should be noted that working in partnership, where all parties accept that each is working in good faith, is a necessary component of delivering positive, effective outcomes for workers. The Welsh Government and NHS Employers met regularly with the health unions throughout the pandemic. This reflected the Welsh Minister's commitment to this style of social partnership working. At an all-Wales level this meant there was better communication and feedback than there otherwise would have been, leading to some improvements for workers and unions. For example, the Welsh Government regularly briefed trade unions on PPE stock levels and discussed beneficial changes to the operation of sick pay.

'Command and control' leadership on the ground

73. On the ground, however, a 'command and control' approach was taken in which authorities at the local level failed to engage effectively with unions. This began early in the pandemic and, despite union representatives' efforts to reinforce the social partnership principles, persisted into 2023. Should a future crisis occur, similar to Covid 19, then health board managers should ensure that they always fully consult with trade union branch officials, through the existing union-management structures.

74. For example, some employers took the decision to introduce higher overtime rates to address staffing shortages. While unions support better pay for workers, the lack of consultation meant that staff working side by side were given different overtime rates. The inequality was increased further by a change to national terms and conditions for part-time workers, again without union consultation. The extent of the disparity was such that, in some cases, part-time workers were paid more than their full-time counterparts. The decision to fast-track students into the workforce was similarly made with limited union engagement. Rather than allowing trade unions to contribute to discussions about staffing and pay, unions were left to respond to decisions taken and, in many cases, to challenges those decisions.

75. In addition to the predictable resentments created by the introduction of unequal pay rates and other unilateral staffing decisions, the lack of partnership and the 'command and control' approach left some health workers feeling like cannon fodder. In the longer term, this type of decision making may explain poor workplace retention.

(E) INFECTION PREVENTION AND CONTROL ("IPC")

Lateral Flow Tests (LFTs)

76. The introduction of LFTs was of limited effectiveness in protecting healthcare workers given the frequency of inaccurate results. Although health workers were aware that LFTs often gave false negatives, symptomatic health workers reported continuing to work until they returned a positive result and received the formal instruction to isolate.

77. On 3 April 2020, Wales TUC wrote to the Welsh government to say: *"The Welsh Government needs to publish a clear strategy for their intentions around testing the workforce in both health and social care, including whether family members will be eligible for testing. This has arisen out of concerns about different strategies being adopted locally. A shift towards anti-body testing is critical. Much greater transparency and better public data on testing is also needed so that unions and others can effectively scrutinise."* [**Exhibit AM/16** - INQ000068455]. The Welsh Government responded to the Wales TUC's concerns on this matter through the shadow Social Partnership Council. By September 2020, the Welsh Government established a Health and Safety Forum where employers, unions and the Health and Safety Executive (HSE) met to discuss responses to these issues.

Information about PPE availability

78. Early in the pandemic, there were discrepancies between the reported stock of PPE and the PPE actually available to workers attempting to access it on the ground. On 3 April 2020, the Wales TUC wrote to the government requesting "*figures on stock levels put in proper context and modelling on projected demand*". **Exhibit AM/16** -

INQ000068455]. The causes of the early mismatch between reported and actual levels of PPE are still unclear.

79. The government subsequently began to brief trade unions on stock levels, anticipated usage, and the length of time for which stocks would last. It was Wales TUC's experience that government officials were open and honest in these briefings. The "traffic light" chart provided some weeks into the pandemic was useful, though it was only introduced as issues with PPE availability were already in the process of being resolved. Even after the briefing system was in place, Wales TUC continued to notice occasional discrepancies between reported and actual PPE stocks.

Inadequate PPE and Inappropriate PPE management strategies

80. The decision to introduce masks to healthcare settings was late coming. After masks were introduced, inadequate fit testing for FFP3 masks made them less effective in preventing the spread of the virus. Problems with fit testing were exacerbated by the fact that there were multiple types of FFP3 masks, which each had to be fit tested separately. At one stage, the dye required to fit test masks was unavailable, leaving workers with an increased risk of infection (see my notes of a meeting between the Welsh Government, the NHS and health unions on 28 April 2020) [Exhibit AM/54 - INQ000339543].

81. Problems with the introduction of FFP3 masks pointed to an adjacent difficulty: there were limited options available for workers whose faces were unsuited to FFP3 masks. Unions were advised of problems fitting FFP3 masks and the lack of respirator hoods - an alternative to FFP3 masks - on 28 April 2020, and brought the issue to the attention of the Nosocomial Transmission Group (NTG) and Business Committee. However, there was no adequate response. It had been assumed early in the pandemic that assumed that everyone would be able to wear FFP3 masks. I exhibit a document listing the concerns reported to the Wales TUC about health and safety in workplaces in April 2020, which was shared with the Welsh Government – inadequate masks are a recurring issue [Exhibit AM/55 - INQ000339544].

82. On 3 April 2020, Wales TUC wrote to the Welsh government with a range of concerns, including that healthcare workers were unable to access suitable PPE or socially

distance [**Exhibit AM/16** INQ000068455]. In response to trade union concerns, the Welsh Government and NHS Wales set up a regular meeting with trade unions to share progress on the procurement and distribution of PPE.

83. The lack of PPE meant that healthcare staff were encouraged to be "sparing" in their use of it, particularly during the first months of the pandemic. A GMB representative said that ambulance staff were constantly told not to use the higher specification FFP3 masks because they would run out and therefore be unavailable when they were "needed". There was no doubt that ambulance staff already needed FFP3 masks. In some instances, workers were allocated pre-determined amounts of PPE for the day, imposing a "moral pressure" on staff to avoid using what they actually needed. In the GMB representative's view, guidelines on the use of PPE were determined with a view to rationing and preserving the available PPE, rather than with reference to the equipment actually required to protect workers.

84. On 11 April 2020, with the issue still unresolved, UNISON Cymru/Wales formally wrote to the First Minister of the Senedd [Exhibit AM/56 - INQ000339545]. This letter followed reports from our branch network of still inadequate levels of PPE across hospitals and care homes in Wales.

85. On 12 April 2020 the Wales TUC and the BMA wrote a joint letter to the Welsh Government calling for clarity on PPE [Exhibit AM/57 - INQ000339546].

86. The Welsh Government did not follow the UK guidance to reuse PPE. Nevertheless, a GMB representative reported that staff in Welsh hospitals were being encouraged to share PPE that should have been single use, including versa-flow hoods that workers would breathe through for entire shifts. When staff complained, they were told that they had no choice. Staff were alarmed by the risk of infection created by reusing colleagues' hoods, and the suggestion was only dropped after significant resistance from Unite. I was told by CSP members that the advice regarding appropriate PPE appeared to be based on availability rather than the level of protection afforded [Exhibit AM/58 - INQ000339547].

87. The inadequacy of suitable PPE led some workers to resort to wearing bin bags or buying visors, goggles and hairbands on which to hook poorly-fitted facemasks. Staff would train each other in how to make protective clothing from the materials they had available. In some places, homemade PPE was donated to workers. The use of whatever protection was available sometimes increased workers' risk of infection and, in some situations, led to workers being reprimanded by their employers in health boards.

88. The CSP, along with other unions, had to inform their members to risk assess their own PPE requirement. For example, the guidance from Public Health and Health Boards informed Physiotherapists that they could perform "suction" interventions without FFP3 masks, because those interventions were not classed as "aerosol generating" procedures. After physiotherapists expressed alarm at the obvious risk of infection created by such procedures, the CSP told workers to risk assess and make their own decisions as to appropriate PPE for such procedures [Exhibit AM/59 - INQ000339548]; [Exhibit AM/60 - INQ000339549].

89. The quality of PPE was another issue. Even when they had access, many workers reported that their PPE was poorly fitted and made them sweaty, making it difficult to work. Although some workplaces allowed breaks for workers using PPE in recognition of their discomfort, that was not necessarily standard practice. Workers in healthcare settings with low quality PPE were left exhausted, thirsty and more likely to feel faint while doing their jobs.

90. Whilst all of the above general points on PPE apply to the Welsh Ambulance Service Trust (WAST), specific attention needs to be drawn to the issuing of Versa flow hoods. These are breathing apparatus that covers the whole head of the clinician. It was suggested at one point by management that these vital pieces of PPE were shared by staff. These hoods were used by staff for long periods of time and staff were breathing in and out into the hoods. To pass on the hood to a colleague once a shift had finished would have undoubtedly caused more infection and the very suggestion was very alarming to staff. The suggestion was dropped but only after significant resistance from Unite. In other cases, there was limited access to versa hoods when employees failed FFP fit testing.

91. Referring to the early weeks of the pandemic at the Welsh Ambulance Service, a GMB workplace representative at WAST said:

> *"PPE was minimal and staff were constantly told not to use the higher specification FFP3masks because they would run out and wouldn't have them when they were needed. However, in staff's view, they were needed at that point.*
>
> *Some PPE that should have been single person use was shared by several staff. Staff complained about this and were told that they had no choice. Some staff were disciplined for not responding to an emergency call even though they clearly informed management that they had no PPE which fitted them."*

Disparate impacts of the lack of suitable PPE

92. The effects of the lack of, or inadequate supplies of, PPE were felt most acutely by BAME workers and women.

93. For example, members of certain ethnic groups were less likely to pass a fit test for FFP3 masks. In those circumstances, the lack of alternatives meant that workers either had to continue their work without adequate protection or avoid working where there was a risk of infection.

94. PPE was often badly suited to women's bodies: women reported feeling sweaty and uncomfortable under the weight of heavy PPE. It was even less suitable for pregnant women. in the Wales TUC's April 2020 report "*Equality impacts of Covid-19*", referred to above [Exhibit AM/23 - INQ000339510], collated survey responses from trade union members and concluded: "*PPE is a huge issue in workplaces. The availability of it, the quality of it, and for women, the fit. Women dominate our lowest paid jobs, and the jobs most likely to be working on the front line of this crisis*."

95. Health workers with hearing impairments felt as though their presence at work was at times an irritation to other colleagues because PPE hindered communication.

96. Access to PPE varied based on the sectors in which healthcare staff worked. The "*Equality Impacts of Covid-19"* report referred to the development of a "hierarchy of PPE", with doctors and nurses in Covid-19 wards being given access but those in social care settings or in public domains at greater risk. Allied Health professionals were repeatedly told that they were not to use PPE at all. Community healthcare workers had "the most difficulty" accessing PPE. Staff reported that they felt less important than their hospital counterparts, treated as "2nd or 3rd class". They had to manage with whatever equipment was available, rather than having access to the PPE required by the guidelines. UNISON stated that even after the PPE shortages had been somewhat resolved, PPE was still in short supply for community workers. IPC guidance for community workers created additional logistical pressure on patients receiving health care in their own homes. This was particularly the case for those with smaller accommodation and additional family members. This impacted patient care. Facilities workers, who played an integral role in infection prevention and control, reported feeling dispensable in comparison to other workers as PPE was prioritised for medical staff.

Vaccine availability for health staff

97. Initially, groups of critical workers – including those who worked in facilities management in hospitals – were overlooked as being a high priority for vaccination. In January 2021, Wales TUC wrote to the First Minister, saying: *"We appreciate that the approach to vaccine roll-out in Wales is based on the work of the Joint Committee on Vaccination and Immunisation on order of clinical risk. However, you will be aware that several unions have requested that the occupational groups of critical workers which they represent should be prioritised for vaccination, as these workers are required to continue working outside the home in order to keep essential services running, and are continually at higher risk in public-facing roles."* [Exhibit AM/61 - INQ000339550].

98. Workers also became resentful about non-clinical managers who were working from home being able to receive spare vaccines before frontline staff. This was largely because when emails were sent out about spare vaccines, only those in front of computers (i.e. managers) were able to see them in time and had the flexibility to travel to vaccination centers.

99. WAST staff had particular difficulty accessing vaccines. They worked long and strenuous shifts and many were attending hospitals on a daily basis. WAST staff therefore felt aggrieved that they were treated differently to other NHS staff. Paramedics asked why waiting times at hospitals could not have been used for them to get vaccinated, given the obvious need for them to be protected.

The Health and Safety Law

100. Unions received concerns from members about the relationship between the Health and Safety Law and the IPC guidance. UNISON and other unions authored a guidance document to assist representatives to understand the necessary steps after an infection or death.

101. Concerns were raised by members about the practicality of adhering to IPC advice. It has been highlighted that IPC guidance adherence was impossible in certain situations, mainly due to the unsuitability of the workplaces in which the guidance had been applied. For example, the guidance required staff to maintain a 2-metre distance between each other, when not wearing masks. In many environments, due to the size of rooms, and corridors, it was not possible to do so. This created confusion, particularly for health and safety officers whose responsibility it was to 'police' adherence. Lack of access to PPE also made adherence difficult – in community settings it meant some individuals had to fashion their own aprons from black bags. Similarly, lack of fit testing equipment led to certain individuals wearing masks that would have been unsuitable for them.

(F) HEALTH AND SAFETY EXECUTIVE (HSE)

102. The HSE operates in a relatively uniform pattern across Great Britain. The Wales TUC shares the TUC's concerns about the HSE's operations during the pandemic and I understand that a statement has been provided by the TUC in this module addressing that topic, to which I defer.

(G) INVESTIGATION AND REPORTING OF WORKPLACE DEATHS

103. There was a mixed understanding and interpretation of Health and Safety Law and IPC guidance. To resolve this issue, UNISON and other NHS trade unions authored a guidance document in July 2020 to aid health and safety representatives in understanding the necessary steps following a case of infection or death related to the Covid-19 virus [Exhibit AM/62 - INQ000339551]. The document explained that the decision to report an incident to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) is an employer's duty, however in the event of refusal report an incident under RIDDOR, where there is reasonable evidence of occupational exposure, it recommended recording this concern in a letter to the employer and provided suggested wording for that letter.

104. However, it continued to be the case that the application of Health and Safety Law regarding RIDDOR reporting of Covid-19 was varied. With few exceptions, RIDDOR reporting of Covid-19 was lower than expected. In one such example, the policy of one large employer was to record instances of 2 infections via DATIX rather than RIDDOR. DATIX is a Risk Management Information System designed to collect and manage data on adverse events (as well as data on complaints, claims and risk). The purpose of collecting such data is to identify learning and implement improvement. The ultimate goal is to make healthcare safer for NHS patients and staff through shared learning and continuous systems improvement. Hence, DATIX is essentially a quality improvement tool. RIDDOR a statutory instrument of Parliament, regulating employers' obligation to report deaths, injuries and illness as well as dangerous occurrences that take place at work or in connection with work. RIDDOR plays an important role in collecting data on annual and historical levels of work-related injury and fatalities, triggering investigations into occupational safety, ensuring employers follow protocols, and helping safety regulators direct support and enforcement powers. Recording a Covid infection on DATIX rather than RIDDOR may have contributed to the under-reporting of Covid infections on the main statutory register for workplace illnesses.

105. Additionally, the criteria set by the HSE for RIDDOR reporting of Covid-19 was particularly unsuitable for health sector workers until an amendment in late 2020. Prior

to this amendment, "work with the general public" was not considered to be sufficient evidence to submit a report.

106. The CSP observed that, even after the amendment, there was little to no RIDDOR reporting of Covid-19 cases and a general unwillingness to accept that individuals were catching Covid-19 at work. [Exhibit AM/63 - INQ000339552]; [Exhibit AM/64 - INQ000339553]. One effect of the low RIDDOR reporting was that employees had less access to Injury Allowance.

107. Beyond that detailed above, I do not have any evidence to provide on steps taken by the Wales TUC or its affiliated unions for deaths of healthcare staff to be investigated.

(H) LONG COVID

108. I understand that the TUC has provided a separate statement in this module explaining why it considers that Long Covid should be recognised as an occupational disease. The Wales TUC fully supports the TUC in this regard and I defer to that statement here.

(I) CONCLUSION AND RECOMMENDATIONS

109. The courage and dedication of the health workforce to patients, despite fears for both their and their family's safety, must be recognised, along with the scarring effect of the pandemic on so many – both physical and mental.

110. The experience of the pandemic for many Black, Asian and Minority Ethnic workers also requires heightened attention and scrutiny. We have heard from many members that racism and discrimination played out in numerous ways, including in terms of access to PPE and other forms of protection.

111. In Wales, the presence of structured and developed social partnership working for the NHS workforce unions, their employers and government provided a good

foundation on which to engage during the pandemic. We hope the inquiry recognises that this is an aspect of preparedness that is often overlooked, as this is not unique to any type of pandemic or crisis, but absolutely crucial as it provides partners with intelligence, a space for policy development and a forum in which to manage transition that is almost impossible to create rapidly.

112. At times, NHS workers felt that policymakers did not have a good grasp of what was necessary to protect the service, and there were gaps on occasion between the national policy intent and local application.

113. Nonetheless the existence of the Business Committee, and commitment of the Welsh Government and NHS managers to hear from unions meant that there was a way to seek to resolve the many issues that arose. The agreement of extended sick pay was secured through social partnership, serving as a good example of responsive decision making that protected patients and staff.

114. More broadly, social partnership working provided (often weekly) opportunities for unions to be informed about crucial information, such as the availability of PPE, tests and, later in the pandemic, the roll out of vaccines. This was a welcome and important step that enabled unions to shape the guidance issued alongside these measures and inform the Welsh Government of workers' frontline experiences.

115. It is clear from experience at a national level that partnership working was key in the pandemic response. However, this was often lacking on a local level. This caused significant issues, especially within trusts that reverted to a complete command and control structure. At times of national crises, facility time for trade union activities should be increased. Trade union representatives should be enabled to work in partnership with local leaders to develop plans, respond to and feedback on local issues.

116. The wider context is an important consideration. As noted above, in paragraph 34, the NHS in Wales faced funding difficulties as it entered the pandemic. The Health Foundation observed that this was causing challenges in the recruitment and retention of staff as far back as 2016. The problems relating to staff shortages impacted the ability of the NHS in Wales to provide services. They severely affected the morale and ability of remaining staff, placing extra burdens on them.

117. It is vitally important that the UK and Welsh Governments adequately fund the NHS so that the recruitment situation can be properly addressed. This includes responding to the legitimate demands for restoring pay levels. It is fair to say that by March 2020, staff had already worked through years of unrelenting strain.

118. The pandemic was the most demanding and expansive crisis that the Welsh NHS has ever had to contend with. There were numerous issues but also a number of examples of joint problem solving, and this increased as the pandemic went on. It is important therefore that the NHS in Wales, the Welsh Government and unions continue to work in social partnership and further embed this approach throughout the system, so that the service is as prepared as it can be for any future crises.

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

Adam Morgan

Dated: **22 January 2024**