UK COVID-19 INQUIRY

MODULE 3- CLOSING STATEMENT ON BEHALF OF THE WELSH GOVERNMENT

1- Introduction

1. This closing statement should be read with the Welsh Government opening oral and written statements and its oral closing statement. It seeks to address, within the constraints of a 40-page limit, the Welsh Government's response to the principal issues arising from the evidence heard in Module 3.

2- The Welsh Government's role

The Civil Contingencies Act 2004

2. The concept of *"command and control"* of the healthcare response to the pandemic does not translate easily to the structure of the NHS in Wales. NHS Wales has no legal entity in contrast to NHS England and there is no single body with an Emergency Preparedness Resilience and Response function within the NHS in Wales. Each local health board and Trust are Category 1 responders under the Civil Contingencies Act in their own right.

3. Responsibility for operational decision-making usually, but particularly during a pandemic, lies at the local level.[1] The Welsh Government's role is primarily strategic planning, oversight and leadership of the NHS in Wales.

The Planning and Response Group

4. In February 2020, the Welsh Government recognised the significance of the emerging threat and established the Health and Social Services Group's Planning and Response Group.[2]

5. The Planning and Response Group brought together the skills, knowledge and perspectives of senior officials within the Welsh Government (including Director General of the Health and Social Services Group, the Chief Medical Officer for Wales

[1] Dr Andrew Goodall, 30/194/1-15.
[2] Dr Andrew Goodall, 30/196/6-23.

(CMO(W)), the Chief Nursing Officer for Wales (CNO(W)) with directors of the local health boards.[3]

6. Significantly, the Planning and Response Group reported directly to the Minister for Health and Social Services and so the overall healthcare response in Wales was co-ordinated at Cabinet level as a public health emergency. The Planning and Response Group also gave Cabinet a clear understanding of the pressures and measures in the NHS in Wales, when making decisions about, for example, non-pharmaceutical interventions.

7. The Planning and Response Group's sub-groups provided a focus on important elements of the pandemic response including Primary Care, Essential Services, Digital Services and Acute Secondary Care.

8. The Inquiry has evidence from the local health boards *that "the relationship with Welsh Government and other organisations was positive. The aim was to maintain open and consistent communication"*[4] and the Planning and Response Group structure allowed for "*lines of communication, and responsiveness, [which were] as good as could be expected in the very difficult circumstances."*[5]

9. The Planning and Response Group ensured national co-ordination of the healthcare response in Wales. Although neither the Health and Social Services Group nor the Planning and Response Group have the size or resources of NHS England, the Planning and Response Group's structure could be successfully used in a future pandemic.

10. In 2023, the NHS Executive was established to provide more centralised capacity for the leadership and oversight of the NHS in Wales and sought to apply the lessons learned in the pandemic.[6] In particular, the NHS Executive has a clear role in supporting the NHS's operational preparedness and in Emergency Planning, Resilience and Response at a national level.[7]

---

[3] INQ000066199/2-4.
[4] INQ000480136/60.
[5] INQ000475209/32.
[6] Vaughan Gething, 35/8/10-20.
[7] INQ000485240/9.

11. There should be a national Category 1 responder for Wales.[8] Unfortunately, the Civil Contingencies Act is reserved to the UK Government and so the Welsh Ministers have no relevant functions under Part 2 and the power to make emergency regulations rests solely with UK Government Ministers.

The use of Ministerial Directions

12. The Planning and Response Group was built on longstanding collaboration between the Welsh Government and NHS bodies which ensured that decisions and policies reflected the views, expertise and experience of those responsible for their implementation.[9]

13. Although the Minister for Health and Social Services has the power to make directions[10] with which the NHS bodies are required to comply, the Welsh Government instead chose to communicate its decisions and policies to the NHS bodies in the form of guidance and requests in most cases and following discussion with them.[11]

13 March 2020 Framework

14. This collaborative approach is clear from the 13 March 2020 framework of actions ('the Framework') which included the suspension of non-urgent outpatient appointments and the suspension of non-urgent surgical admissions and procedures. In particular:

    a. During the week of 9 March 2020 local health board Chief Executives expressed significant concerns about the projected increase in case numbers. Departments were already losing staff to sickness and the potential for further staff shortages was recognised.

    b. On Wednesday 11 March, the Critical Care and Trauma Network asked the Minister for Health and Social Services for elective surgery to be stopped immediately to allow them to address bed capacity, release staff for training and upskilling and provide capacity to address the emergency surgery backlog before the peak.[12]

[8] Dr Andrew Goodall, 30/200/7-19.
[9] Dr Andrew Goodall, 31/78/15 - 31/79/7.
[10] Under S.204(3)(c) NHS (Wales) Act 2006.
[11] Dr Andrew Goodall, 30/190/21 - 30/191/15.
[12] INQ000252505/1.

c. Discussions with local health boards continued: for example, the Chief Executive of Hywel Dda University Health Board wrote to Dr Goodall that *'the developing view locally is that we should take urgent action to reduce non-urgent surgery and related activities'"*.[13] An email from the Chief Executive of Cardiff and Vale University Health Board said, "*a decision on in patient elective activity should be taken this week".*[14]

d. On Friday 13 March, Dr Goodall wrote to his counterparts in England, Northern Ireland and Scotland that there was a *"very strong feeling coming through our system at the organisational and clinical level for a change of preparations...in practice, organisations who have already been in receipt of patients have already been making judgements to cancel routine activities as a necessary response*".[15]

15. The Framework was significant: it provided Government support to local health boards to take the operational decisions and actions they considered necessary.[16] Local health boards did not require the Welsh Government's permission or support, or a direction to pause routine care or to redeploy staff. The Framework sent a strong message to the public and the NHS that immediate action by local health boards was necessary and it reinforced to the public the nature of the threat faced by the NHS in Wales. The Framework also removed a policy and administrative burden from the local health boards.

16. It was neither necessary nor appropriate for the Framework to be issued under a ministerial direction or to prescribe its application.[17] As Professor Kloer said, there was a lag in cases reaching West Wales and the first wave hit different areas of Wales at different times and in different ways. Local health boards were best placed to assess and respond to local circumstances and to maintain routine care as long as they could.

17. The Framework was an example of national leadership which informed local decision-making and underpinned the close collaboration between the Welsh Government and the NHS to best meet patient need.

---

[13] INQ000479918/1-2.
[14] INQ000479916/1.
[15] INQ000492671/1.
[16] INQ000198262/1-2.
[17] Vaughan Gething, 35/17/1-14.

Quarterly Operational Frameworks

18. In May 2020, the Minister for Health and Social Services directed that local health board planning should move from a 3-year cycle to the Quarterly Operational Frameworks. They informed the regular consideration of the developing advice and modelling with the evidence about the pressures faced by the NHS which allowed the Welsh Government to set priorities for local health boards.[18]

Improvements for the future

19. The approach under which the Welsh Government set strategic priorities, guidance and policies and the NHS Wales bodies are responsible for implementation reflects the statutory arrangements for providing healthcare services in Wales. It is, however, recognised that there is evidence of avoidable inconsistencies which are neither explained nor justified by local requirements.[19]

20. The Welsh Government therefore proposes the establishment of arrangements to ensure greater consistency in the implementation of Welsh Government policy by NHS bodies in Wales. This proposal is aimed at ensuring greater consistency without interfering with or limiting health boards' discretion to tailor clinical provision to local needs. Any such process will sit alongside the duty placed on the NHS in Wales and Welsh Ministers by The Health and Social Care (Quality and Engagement) (Wales) Act 2020 which came into force on 1 April 2023 and introduced a duty to ensure the quality of health services in Wales.

3- NHS Capacity

The starting point

21. At the outset of the pandemic the Welsh Government had just 152 critical care beds.[20] Before the pandemic it was common for Welsh hospitals to be operating at an extremely high capacity level. The University Hospital Wales reports operating at 90-95% critical capacity prior to the pandemic. This *"had been raised nationally with Welsh Government that critical care capacity was one of the lowest in the UK and Europe per head of population".*[21]

[18] Welsh Government Opening Statement/2-3
[19] Welsh Government Closing, 39/167/12-17
[20] Dr Andrew Goodall, 30/215/20-23.
[21] INQ000480136/23.

22. The Welsh Government recognised from 13 February 2020 that action would be required to increase capacity across the NHS in Wales, not just in critical care and the need for isolation facilities and appropriately trained staff in particular.[22] As above, the structure of the NHS in Wales mandated that the actions required to increase capacity were developed and deployed at a local level by local health boards. The Welsh Government requested action to be taken and asked for regular reports on the success of the actions taken throughout February and March 2020. The Welsh Government communicated the modelling and provided strategic guidance in the form of capacity targets but the Welsh Government could not and did not dictate how local health boards, which were best placed to decide operational matters, increased or freed capacity in their areas.[23]

23. The Welsh Government supported local health boards, for example through the early handover of parts of the newly built Grange University Hospital to Aneurin Bevan University **Health** Board to provide 350 additional beds to support the care of patients without Covid-19 or recovering patients who no longer needed acute care but needed support before moving to their next care setting .[24]

24. The NHS bodies in Wales made extraordinary efforts to increase the capacity such that by 4 April 2020 there were 356 available critical care beds with a further surge capacity of 90 beds that could be made available within 24 hours, 89 that could be made available within 7 days and 229 after more than 7 days.[25] The Welsh Government accepts that, until 13 November 2020 the reporting focused on whether or not the bed existed and did not reflect whether or not it could be staffed.[26]

25. At no point were global bed capacity limits breached in Wales. Therefore, throughout the pandemic the NHS in Wales had available surge capacity in hospital and critical care beds.[27] That was achieved due to the extraordinary efforts of NHS bodies to increase their capacity and to the exceptional efforts of the staff.[28]

---

[22] INQ000227377/1-2.
[23] INQ000485721/169-171.
[24] INQ000144857/1-6.
[25] INQ000485721/167.
[26] INQ000485721/179.
[27] Vaughan Gething, 35/111/19 - 35/112/12.
[28] Dr Andrew Goodall, 31/103/10-24.

Data collection on capacity

26. As Dr Suntharalingam confirmed, it is much *"more difficult than you would think"* to report on capacity, to get a national picture, not least where that picture will change minute by minute.[29] It is essential, in order to understand the experience of the staff at the bedside, to reflect the difference between baseline capacity, current capacity and surge capacity available.[30]

27. It is for the local health boards to monitor their available capacity in order to take operational decisions about how it should be used. From 20 March 2020 the Welsh Government collected daily reporting from local health boards about their capacity to inform its strategic functions and decision-making. The collected data, and how it was aggregated, was shaped by the purpose for which it was collected, collated and presented.

28. Circulation of the sitreps allowed decision-makers, in particular the Minister of Health and Social Services and the Cabinet, to understand the pressures faced by the system during the pandemic as well as the spread and development of the virus. The reports informed decision-making about funding of non-pharmaceutical interventions and allocation of resources

29. As the pandemic progressed, the reporting of data was refined and improved. A baseline was added so that the extent to which the system was utilising its surge capacity was clear as well as the distinction between the number of immediately available beds, those that could be made available within 24 hours and seven days. It is important to note that this detail was always available to the Welsh Government from the local health boards' own reporting.[31] It could have been better presented and collated to better help local health boards to optimise care but the reality is that all the local data was available to local health boards at all times.[32]

30. The Inquiry cited evidence from the Chief Information Officer for Cwm Taf Morgannwg Health Board that the way that data had been collected and aggregated led to confusion about the recording of the use of CPAP devices which meant that they were unable to evidence whether they had sufficient CPAP machines in the first and second

[29] Dr Ganesh Suntharalingam, 15/60/17 - 15/61/8.
[30] 15/65/5-15/66/1.
[31] Dr Andrew Goodall, 31/8/8-19.
[32] Dr Andrew Goodall, 31/11/15-21 and 31/12/14-24.

waves.[33] The Welsh Government's sitreps listed the number of CPAP machines available and in use at any given time based upon the data reported by the local health boards.[34]

31. The adoption of CRITCON in December 2020 helped to analyse and track the pressures on critical care capacity and resources and CRITCON would be useful in a future pandemic. Before the introduction of CRITCON the Welsh Government relied upon the data, coupled with the cooperation and reporting from the Critical Care and Trauma Network which linked frontline clinicians across Wales. This was possible in Wales because of the relative size of the network where clinicians had regular and at times daily contact, and contact with the Welsh Government through the Planning and Response Group, the Health and Social Services Group or with Dr Goodall directly.[35]

Qualitative evidence

32. Quantitative data alone did not provide a complete picture of the pressures faced within the NHS in Wales during the pandemic, or of the pressure on frontline staff.

33. The provision of mutual aid and the transfer of patients between hospitals or local health boards demonstrates how the cooperation between local health boards, assisted by the Critical Care and Trauma Network, functioned. Individual hospitals or local health boards would contact their colleagues in the network, most of whom they knew well, to discuss and broker the support they required. This would occur at a local level and did not require the involvement of the Welsh Government to facilitate or oversee it. However, the Welsh Government recognises that an understanding of the extent to which that process was required or occurred during the pandemic would have provided a valuable insight into the operational pressures.[36]

34. Professor Fong's evidence was powerful and the evidence he provided to the UK Government during the pandemic was invaluable. The Critical Care and Trauma Network gave the Welsh Government some insight into the pressures on local health boards as did the regular engagement that Dr Goodall, members of the Planning and Response Group and the Health and Social Services Group and the CMO(W) or the CNO(W) had with their colleagues within the system. However, the Welsh Government

[33] INQ000409575/19.
[34] INQ000421646.
[35] Dr Andrew Goodall, 31/16/16 - 31/17/21.
[36] Dr Andrew Goodall, 31/17/25 - 31/19/06.

agrees that it would benefit from a formal scheme to allow it to use that information more effectively.[37]

Staffing capacity

35. Expanding critical care services meant more than increasing the beds and space available. One of the significant challenges for the NHS in Wales was to identify staff capable and available to staff the additional beds.

36. The process by which the critical care nursing ratios in Wales were adapted demonstrates the interplay between Four Nations cooperation, Welsh Government-level policy-making and local implementation. The Welsh Government did not mandate nursing ratios nor how this staffing challenge should be met. The guidance was produced at a Four Nations level by the UK Critical Care Nursing Alliance which devised a number of options. At a Welsh Government level, advice was provided by the CNO(W). Policy officials worked with the Wales Critical Care and Trauma Network to identify what would be appropriate in NHS Wales's critical care settings. In doing so, the Welsh Government relied heavily on the experience and expertise of clinicians in the field, in Wales and across the Four Nations. In addition, the CNO(W) shared the information available to her with Nurse Directors to equip them to make the best decisions locally.[38]

37. Although the options provided by the UK Critical Care Nursing Alliance countenanced a ratio of one critical care nurse to six patients, the process described above allowed those working within the Welsh system to say they would not be comfortable with the proposed dilution. The Welsh guidance advised that one nurse could care for three Level 3 critical care patients in extraordinary circumstances.[39] The Inquiry heard from Professor Kloer that Glangwili Hospital never went beyond one nurse to two Level 3 critical care patients. They continued to provide one-to-one nursing for ventilated patients and those requiring CPAP received one-to-two care.[40] Outside of critical care, the ratios in medical wards were extremely stretched, with one nurse to anything from 20 – 24 patients.

[37] Dr Andrew Goodall, 31/20/15 - 31/21/9.
[38] INQ000480133/73.
[39] Professor Jean White, 06/104/11 - 06/105-2.
[40] Professor Philip Kloer, 30/139/3-8.

38. The Welsh Government was not responsible for 'overseeing' or 'monitoring' the implementation of this guidance or the local decision-making but, with the benefit of the Critical Care and Trauma Network, the information was available to Welsh Government officials about the staffing ratios in use at times of particularly high demand (for example in December 2020-January 2021).[41] This information was one of many ways that the Welsh Government could 'reach into' the NHS in Wales to understand or quantify the burden on the system. Likewise, although nursing ratios were not dictated by the Welsh Government when concerns were raised about nursing ratios the Welsh Government was able to meet representatives of the Critical Care and Trauma Network, NHS Directors of Nursing and NHS Chief Executives to explore and, where possible, resolve those concerns.

Field hospitals

39. The decision to begin the field hospital programme was made in light of modelling provided on 15 March 2020 which estimated that at the pandemic's peak there would be a deficit of -5,989 beds at peak and -1,447 ICU beds if all current NHS capacity was available. In fact, the advice was that the deficit was likely to be higher. This was subsequently revised to forecast the need for 900 critical care and an additional 10,000 system-wide beds at the point of peak demand. Each local health board developed its own local plan for building the extra surge capacity required either by using existing hospital sites, private healthcare providers or setting up field hospitals.[42]

40. The Welsh Government provided strategic oversight of the field hospital programme and the necessary funding.[43] Funding applications were scrutinised by health officials, the Minister for Health and Social Services and the Star Chamber which critically scrutinised the funding and purpose of field hospitals.[44]

41. Dr Goodall wrote to local health boards on 24 April 2020 to ensure that they did not commission or use field hospital capacity unless it was needed.[45] Local 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. As the pandemic developed, field hospitals were used differently than first anticipated. In the first wave field hospitals were set up to address the anticipated

[41] Professor Jean White, 6/105/6-21 and 6/108/11 - 6/110/9.
[42] INQ000474252/102.
[43] Vaughan Gething, 35/31/8 - 35/33/9.
[44] INQ000474252/103.
[45] INQ000395661/1.

reasonable worst-case scenario with capacity needed for end-of-life care. Later, rehabilitation and recovery became the greater focus of field hospitals. Some were used as testing hubs, for storage or as training sites.

42. The Welsh Government recognises that, allowing for their adaptation and re-purposing, many of the beds created in field hospitals were never used. The field hospitals were a contingency measure and should be seen as such. Given the clear conclusions of the early modelling, the novel nature of the pandemic and so much remaining unknown about the virus, the Welsh Government could not reasonably take the risk that the pandemic would develop in a way which left hospitals overwhelmed and patients without beds.

43. Field hospitals undoubtedly served the pandemic response well. By 22 March 2021, more than 930 patients had been admitted to a field hospital. Having reviewed their use, the Minister for Health and Social Services considered that the additional staff and bed capacity was instrumental in enabling recovering patients to leave acute hospitals which freed much needed capacity in acute and community hospitals.[46]

4- Modes of transmission and the development of scientific understanding

44. The Technical Advisory Cell was the primary source of expert, medical and scientific advice to the Welsh Government. It was established in February 2020 to provide multi-professional independent expert advice specifically tailored to Wales. The Technical Advisory Cell reported to the Planning and Response Group, allowing it to make decisions and policies based on the most relevant scientific and technical advice and guidance. The Technical Advisory Cell was the conduit through which the evidence and advice from the World Health Organisation, SAGE and NERVTAG was reviewed and presented to the Welsh Government. The Technical Advisory Cell enabled Wales-specific modelling to be created.[47]

45. It is right for the Inquiry to explore and test the correctness of the scientific understanding of Covid-19 and its transmission in particular. Welsh Government decisions, particularly those relating to infection, prevention and control (IPC), were informed by and based upon the advice and evidence from the Technical Advisory Cell, SAGE, NERVTAG and the World Health Organisation and they should be judged

[46] INQ000421679/1.
[47] INQ000416178/21.

against that contemporaneous advice and guidance. It is unfortunate that the Inquiry has chosen not to call evidence from those bodies in response to Professor Beggs' report.

46. Much of the IPC approach during the pandemic was developed on a Four Nations basis and co-ordinated by the UK IPC Cell.[48] Dr Lisa Ritchie was clear that it was the IPC Cell's role and responsibility to translate scientific evidence and advice into practical IPC guidelines. If the World Health Organisation, SAGE or NERVTAG had advised there was the evidential basis for airborne transmission, IPC advice would have been revised accordingly.[49] The contemporaneous World Health Organisation guidance on droplet size and precautions had been in place since 1997 and despite a recent review, the World Health Organisation did not change its guidance that the epidemiology and the scientific literature did not support airborne spread as the predominant mode of transmission.[50]

47. Dr Warne very clearly said that his view that FFP3 masks would have offered healthcare workers greater protection was based upon "*the balance of evidence as we have it now.*"[51]

48. In so far as the precautionary principle is relevant, Professor Whitty rightly said that it "*is only a useful principle where there are no downsides, otherwise you're talking about balance of risk.*"[52] Notably, the Inquiry's experts concluded that it is harder to apply the precautionary principle when the threat is on a massive scale because it risks exhausting supplies of PPE for which the precautionary principle advocates.[53]

5- Personal Protective Equipment (PPE)

49. In April 2020, a PPE Supplies Cell was added to the Planning and Response Group. It was directly accountable to Welsh Ministers and to Dr Goodall, and it had close links with NHS Wales Shared Services Partnership which provided PPE stock reports.[54] At a national level, the NHS in Wales did not run out of PPE. Although Wales received

[48] Section 6 below
[49] Dr Lisa Ritchie, 5/105/5-13.
[50] Dr Lisa Ritchie, 5/88/21-89/18
[51] Dr Ben Warne, 8/163/10-13.
[52] Professor Sir Christopher Whitty, 12/142/7-12.
[53] INQ000474282/132.
[54] INQ000474252/122.

mutual aid from Scotland and England, Wales also provided mutual aid to England and Northern Ireland: overall, Wales provided significantly more PPE than it received.[55]

50. The Inquiry has considered the scientific basis for the IPC Cell's advice on the use of FFP3 masks, and the availability of those masks. The decision about the types of PPE procured by the Welsh Government followed Public Health Wales's IPC guidance. The development of that guidance was neither led nor constrained by the availability of PPE or types of PPE in Wales.[56]

51. The Welsh Government does not minimise the significance of the challenge of ensuring adequate national stocks of PPE and its effective distribution to those who needed it. Vaughan Gething accepted that in some respects and for some items the pre-pandemic stockpile was inadequate.[57] Replenishing PPE stock supplies was a greater challenge than had been expected. The Welsh Government was clear about the difficulties it faced throughout the pandemic as exemplified by the Minister's public statement on 21 April 2020 that Wales only had enough stocks of all items to last for a few days.[58]

52. At the outset of the pandemic the Welsh Government believed that it had a six months' supply in stockpile but those stocks were used much faster than anticipated. The stockpile of gloves lasted for only one and a half weeks. In Cardiff and Vale University Health Board staff were initially concerned about the availability of PPE and the preference was for the fullest use of protection as possible, which *"conflicted with national guidelines that had to balance the supply of PPE for a prolonged period"*.[59]

53. Even where there was sufficient PPE stock, there were distribution challenges: "*We didn't run out of stock...we had everything but not necessarily in the right place*."[60] The NHS Wales Shares Servies Partnership rapidly expanded its existing arrangements to supply local authorities (for onward distribution to the social care sector) and GPs, pharmacists, and dental and optometry contractors.[61]

---

[55] INQ000474252/123.
[56] Professor Fu-Meng Khaw, 26/27/8-15.
[57] Vaughan Gething, 35/38/22 - 35/39/22.
[58] INQ000474252/122.
[59] INQ000480136/42.
[60] Professor Jean White, 6 /126/6-10.
[61] INQ000485721/133.

54. There were clearly instances of healthcare workers who were unable to obtain PPE or were so concerned about the availability of PPE that they were forced to adopt unsafe IPC practices such as using bin bags for aprons. Public ministerial statements gave assurance about PPE stock levels, advice about how to access PPE and set up a hotline for workers to ask for PPE.

55. Although the Welsh Government confronted this challenge at a national level, Professor Kloer confirmed that delivering PPE stock to local health boards did not necessarily mean it reached the right hospital or the right ward .[62]

6- IPC

The role of the Nosocomial Transmission Group

56. The Nosocomial Transmission Group was established in May 2020 to provide advice and guidance on the actions needed to minimise the nosocomial transmission of Covid-19.[63] The Nosocomial Transmission Group brought together officials from Welsh Government, Public Health Wales, NHS Shared Services (which was responsible for procuring and distributing PPE), trade union representatives and nursing specialists.[64] The Nosocomial Transmission Group assumed responsibility for producing evidence-based guidance and leadership in IPC (including awareness, education and training). From August 2020 the Nosocomial Transmission Group facilitated, through the Covid-19 Rapid Sharing of Early Learning platform, the sharing of best practice and other learning points within 24-72 hours of incidents.[65]

57. The Nosocomial Transmission Group could have been set up earlier. It was apparent at the end of March 2020 that there were incidences of nosocomial transmission of Covid-19 in Wales. In a future pandemic understanding and addressing nosocomial infections should be a priority and the early use of a dedicated team such as the Nosocomial Transmission Group would provide a significant benefit.[66]

Development of IPC guidance

58. IPC guidance for use in the NHS in Wales was not produced by the Welsh Government. Welsh engagement with the UK IPC Cell was through clinical experts in Public Health Wales who in turn, worked with epidemiologists in each of the six local

[62] Professor Philip Kloer, 30/185/14 - 30/186/4.
[63] INQ000416178/118.
[64] INQ000480133/119.
[65] INQ000480133/184-185.
[66] Vaughan Gething, 35/59/13 - 35/63/8.

health boards and worked directly with their IPC teams.[67] Public Health Wales worked with Welsh Government officials in the Nosocomial Transmission Group which would raise concerns with the UK IPC Cell.[68]

59. The Welsh Government recognises that the practical consequences of the publication of Public Health England guidance on Thursdays, with Public Health Wales guidance following on a Friday created challenges to NHS bodies, to clinical leads and to trade union representatives. Perhaps more significantly the Welsh Government recognises that this created confusion and distrust from healthcare workers required to interpret and adapt as the guidance changed.[69]

Implementation of IPC Guidance

60. IPC guidance is designed to address and reduce nosocomial transmission but it cannot eradicate it.[70] IPC guidance is only as effective as its implementation. Both the Inquiry's experts and the Nosocomial Transmission Group found variations in PPE adherence across the NHS and even within individual NHS organisations.[71]

61. The implementation of IPC guidance is a matter for individual NHS bodies. The Welsh Government endeavoured throughout to provide support, guidance and resources (including the necessary PPE) for effective implementation of the IPC guidance.[72]

62. Healthcare Inspectorate Wales (HIW) provided some oversight of the implementation of IPC guidance in Wales. Its National Review, published in June 2021, noted that positive arrangements were in place to strengthen IPC across the NHS and independent healthcare services, which included a strong focus on hand hygiene, cleanliness and the correct provision and use of PPE. The report highlighted the processes which were introduced to help mitigate the risk of nosocomial transmission and control the spread of the virus.[73]

---

[67] Professor Fu-Meng Khaw, 26/25/25 - 26/27/07.
[68] INQ000480133/113-114.
[69] Judith Paget, 31/144/14 - 31/146/10.
[70] Sir Frank Atherton, 13/52/4 - 13/53/5.
[71] INQ000474282/134.
[72] Vaughan Gething, 35/64/19 - 35/66/5.
[73] INQ000182583.

63. Professor Gould, with the benefit of seven years of practising in Wales described the quality of the service that was offered by the people in charge of local health board IPC services as very good.[74]

64. The Inquiry heard that the guidance was followed at hospital level but that it was interpreted "*more purposively than literally*" because of the need for it to be adapted to the design and nature of the hospital buildings [75] and on occasion the individual spotlight hospitals considered it necessary to depart from the guidance.[76]

65. The Welsh Government agrees with the evidence of Professor Kloer that *"national guidance was certainly not formulated with the physical constraints of GGH in mind but then guidance which is national cannot, in the time frames we were working with, reach that level of sophistication."*[77]

Challenges caused by the NHS in Wales' estate

66. The NHS in Wales is "*stuck by the fabric of our hospital buildings and healthcare settings across Wales."*[78] Much of the NHS hospital estate in Wales is not modern and so it was not easily adaptable to meet the demands of the IPC guidance.[79]

67. As the CMO(W) emphasised, medical directors *"were bending over backwards to try to manage, reconfigure the space, meet the demands of patients coming in through successive waves The estate worked against us in terms of its age and the infrastructure that we had available."*[80] Those challenges were laid bare in the evidence relating to spotlight hospitals:

    a. Professor Kloer described Glangwili Hospital as *"outdated and not compatible with modern healthcare*"[81], with challenges caused by issues including a lack of side rooms and very poor ventilation;

    b. Professor Jenney and Professor Walker highlighted challenges in the University Hospital of Wales: "*the age, condition and functional stability of the*

[74] Professor Dinah Gould, 8/15/8-16.
[75] INQ000475209/13.
[76] INQ000480136/33.
[77] INQ000475209/32.
[78] 31/96/10-20.
[79] Sir Frank Atherton, 13/67/13-19.
[80] Sir Frank Atherton, 13/68/1-8.
[81] INQ000475209/3.

UHW estate presented challenges in relation to meeting standards". They outlined that while critical care units are "*recommended to have 20-50% of beds as single/isolation rooms, UHW critical care had 7%*".[82]

68. In some hospitals the most significant challenge was ventilation. The Welsh Government expected local health boards, which knew their own facilities and recognised their individual and operational responsibilities, to do *"the best they could within their available facilities"* and to use alternative or additional IPC measures to mitigate the risk posed.[83]

69. In June 2020, Dr Goodall gave guidance to the NHS in Wales on bed spacing, social and physical distancing in hospital settings, the use of screens between beds, environmental decontamination and the use of fans.[84] However, a 15 November 2020 position statement from the Nosocomial Transmission Group indicated that a substantial and frequently cited risk for nosocomial spread of Covid-19 was the inability to provide adequate isolation for patients with confirmed or suspected infection because of the lack of single occupancy rooms. It 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.[85] Professor Kloer confirmed to the Inquiry that Glangwili Hospital's initial assessments found in summer 2020 that to implement this guidance would lead to the loss of 113 of 388 beds.[86]

70. Perspex screens were being used between beds to mitigate the risk but that this was an incomplete replacement for distancing. The Welsh Government's NHS Wales Shared Services Partnership identified and shared available options for pop up 'Redirooms' to provide isolation cubicles.[87] The Nosocomial Transmission Group 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 (see above).

---

[82] INQ000480136/37.
[83] Dr Andrew Goodall, 31/97/12-21.
[84] INQ000299554.
[85] INQ000396261/8.
[86] Professor Philip Kloer, 30/136/13-17.
[87] INQ000396261/08.

71. Judith Paget agreed that local health boards faced a *"difficult choice"* between capacity and bed spacing in the interests of IPC.[88] Unfortunately, capital budgets limit the Welsh Government's ability to make the desired improvements quickly and at scale.[89] Additional funding has been made available since 2021 to address some of those issues, with the benefit of advice from engineering experts in the NHS in Wales.

72. The draft budget published by the Welsh Government in December 2024 provided an additional £175m for capital funding in health and social care, to help maintain and improve the NHS estate infrastructure. The most recently built hospitals have an increased number of single rooms. However, much more work, and much more funding, will be needed. As Professor Gould, Dr Shin and Dr Warne stated when providing expert evidence for the Inquiry, upgrading older hospital buildings is expensive and time consuming and the Welsh Government accepts their conclusion that *"there are no quick fixes for improving ventilation or isolation capacity on the ageing NHS estate".*[90]

Visiting restrictions

73. The Welsh Government has accepted the finding of the National Nosocomial Covid-19 Programme (see below) that *"visiting restrictions had many adverse effects on the physical and mental health of patients - especially those in the vulnerable groups that the restrictions were intended to safeguard, many of whom were not able to fully understand the decisions made. The limited alternative arrangements for making contact and communicating with loved ones, also negatively impacted the experience for many other service users, families and carers."*[91]

74. The need for the Welsh Government to develop national guidance on visiting restrictions within Wales was driven by nurse directors within the NHS bodies. It was developed in March 2020 in the context of a *"tremendous amount of fear"*. [92] Throughout the pandemic its development and adaptation required a difficult balance between the risks of visiting and the harm caused by restricting it. The Welsh Government's guidance always endeavoured to be *"as enabling as possible"*, particularly at the end of life. The Welsh Government's ability to conduct that balancing exercise improved as the evidence about the virus and the effect of IPC measures

[88] Judith Paget, 31/141/11-21.
[89] Dr Andrew Goodall, 31/97/4-22.
[90] INQ000474282/131.
[91] INQ000501402_08.
[92] Professor Jean White, 6/130/10 - 6/131/9.

developed.[93] As a result, the guidance became more nuanced and more permissive as the Welsh Government heard about the effect on specific groups including those with dementia, those who needed an interpreter or those using maternity services.

75. Dr Shin agreed that "*a balance had to be struck somewhere*" and in the circumstances of a new rapidly rising infection with high mortality it was "*probably the right decision*" and "*a reasonable step*" to introduce stringent visiting measures at the beginning of the pandemic.[94] The experts gave evidence that in the first wave sustained visiting restrictions had likely reduced nosocomial transmission. Although the implementation of visiting restrictions was likely less of an impact than other IPC measures, Dr Shin was clear that IPC requires the application of many measures[95] and it is very difficult to apportion the relative contribution of each and their importance.[96]

76. As with any guidance for the NHS in Wales, the local adoption and implementation of visiting restrictions was a matter for NHS bodies. There is a risk of inconsistency in the application in different hospitals or local health boards. However, consistency does not mean uniformity. The Welsh Government provided the principles to be applied, and the tools and information required to carry out a risk assessment based upon local circumstances. As described by the Welsh 'spotlight' hospitals, different areas in Wales experienced the pandemic in different ways at different times. There were areas of very high community prevalence while others were very low. Some hospitals are older with few single patient rooms and limited options for adaptation while there are also some hospitals which have many single rooms. Judith Paget confirmed that in her time in Aneurin Bevan University Health Board there would even have been "*different situations in different hospitals at different times which [they] were trying to reconcile.*"[97]

77. Professor Kloer described the general discretion vested in the ward sister (or nurse in charge) directed at allowing visiting when in the patient's best interests, and stated the *"discretionary 'best interests' policy was later reflected in the national guidance on 'purposive visiting' issued by the CNO in July 2020, which was itself a product of the regular meetings held at national level between the nursing heads"*.[98] Professor Kloer echoed the evidence of CNO(W) that visiting restrictions were influenced by

[93] Professor Jean White, 6/132/6-21.
[94] Dr Gee Yen Shin, 8/121/4-19.
[95] Dr Gee Yen Shin, 8/124/6-24.
[96] Dr Gee Yen Shin, 08/129/1 - 08/129/7.
[97] Judith Paget, 31/148/4-10.
[98] INQ000475209/21.

understandable concern from nursing staff about the move to a more purposive approach taking time as staff gained confidence. He agreed with the experts that overall *"the right balance was probably struck"*.[99]

78. The Welsh Government accepts, as the experts did, that there are specific circumstances in which a more permissive approach to visiting restrictions should be taken in a future pandemic such as, for example, the admission of carers for those who suffer from dementia or learning disabilities.[100] For maternity services in particular, the Welsh Government accepts that birthing partners should have been permitted to be present throughout labour, whether active or not, and both parents should have been permitted to remain with children in neonatal services.[101]

79. Although uniformity may not be achievable, the Welsh Government agrees that measures should be developed to avoid inconsistencies which are not justified by local circumstances. There should also be steps taken to provide consistency for key groups.[102]

Testing healthcare workers

80. Throughout the pandemic the Welsh Government recognised the potential benefits of testing both patients and healthcare workers as a means of reducing transmission rates. However, the Welsh Government was always constrained by the availability of tests and laboratory facilities.[103] The National Nosocomial Covid-19 Programme found that increased demand for testing during the pandemic posed a significant challenge to the existing testing infrastructure, which still had to manage routine provisions.[104] The Welsh Government accepts the finding that demand exceeding capacity and the inability to test rapidly for Covid-19 during periods of 2020 meant that testing was somewhat ineffective as a mechanism for reducing infections, until the supply of consumables met demand and testing capacity increased.

81. A chronology of the development of the Welsh Government's testing policy has been provided in the CMO(W)'s first witness statement.[105] At all times the relevant advice

[99] INQ000475209/23.
[100] Dr Gee Yen Shin, 08/122/16 – 08/123/5.
[101] Professor Jean White, 06/134/10- 06/136/25.
[102] Judith Paget, 31/149/19 - 31/150/15.
[103] Sir Frank Atherton, 13/55/16 – 13/56/7.
[104] INQ000501402_19.
[105] INQ000416178/61.

and guidance was provided by Public Health Wales and was the result of a difficult analysis of the availability of tests, the modelling data and the relative risks of the various competing options.

82. The Inquiry has focused on the use of asymptomatic testing for healthcare workers. As Dr Warne noted, the majority of patients' hospital acquired infections were from other patients whereas *"there was a lot of healthcare worker to healthcare worker transmission."* We know now that periodic testing of healthcare workers has only a small effect on the number of hospital acquired Covid-19 cases in patients but it does reduce infection in healthcare workers by as much as 37%, thereby resulting in far fewer staff absences.[106]

83. Given the increasing availability and scientific validation of lateral flow devices, in December 2020 the Welsh Government was able to introduce a programme of twice weekly asymptomatic testing of patient-facing health and social care workers.[107]

84. The UK Government was able to implement a regular symptomatic testing regime more quickly because it had the LAMP[108] technology and laboratory systems in place to support it. For the Welsh Government to take the same approach, it would have required resources and time to train staff which would have created a time lag between the two.

85. When twice weekly asymptomatic testing of healthcare workers was introduced in December 2020, the Welsh Government was confident that it had the supplies and resources required to provide it. It was the Welsh Government's expectation that NHS bodies would adhere to and implement that programme.[109] It is, therefore, disappointed by the evidence that local health boards and hospitals decided to depart from this guidance and did so because of the incorrect belief that there would not be enough tests.

86. When asked about the potential effect of this delay in implementing the asymptomatic testing of healthcare workers, Dr Warne concluded that it would have increased the risk of transmission symptomatic healthcare workers to patients. However, the

[106] Dr Ben Warne, 08/140/1-5.
[107] INQ000485721/126.
[108] The Loop-Mediated Isothermal Amplification (LAMP) test
[109] Vaughan Gething, 35/113/22 - 35/114-5.

absolute increase in numbers may have been small in comparison to other routes of transmission.[110]

7- Nosocomial Transmission in the NHS in Wales

Nosocomial Outbreak reporting

87. Ordinarily, outbreak management in Wales is managed by Public Health Wales but that approach created a delay in the reporting of outbreaks of Covid-19. In order to closely monitor outbreaks, the Nosocomial Transmission Group developed a form which was completed by each hospital on a daily basis. This provided a more up to date and accurate picture from the front line of the outbreaks. It showed how many people were affected and how quickly it was being addressed. The Nosocomial Transmission Group's reporting system allowed it to identify good practice on outbreak management which was shared with those finding it difficult to contain spread of the virus within clinical settings.[111]

88. The Nosocomial Transmission Group's reporting allowed the Welsh Government to understand the direct impact on both patients and staff.[112] The information gathered was shared with officials in the Welsh Government and combined all-Wales weekly outbreak reports were prepared which included a national picture and summarised each individual health board's position noting if the situation was stable, improving or deteriorating and noting examples of what measures were in place to respond to the situation.[113] The reports were shared via the Planning and Response Group meetings and provided an opportunity for signposting senior managers in local health boards where outbreaks were not being well controlled to get in contact with those local health boards who seemed to have gained a quicker control on the spread of disease. The Minister for Health and Social Services received Incident and Outbreak updates.[114]

89. The National Nosocomial Covid-19 Programme found that current arrangements within NHS Wales for the identification, reporting and investigation of all healthcare acquired infections that meet the definition of a patient safety incident are variable and there are inconsistent approaches to their management and reporting. A new Health Care Acquired Infection Delivery Board has been established to further co-ordinate national approaches to learning and improvement across NHS Wales, reducing risks

[110] Dr Ben Warne, 8/184/14-18.
[111] INQ000480133/124.
[112] Professor Jean White, 06/118/22 - 06/120/15.
[113] INQ000480133/124.
[114] INQ000474252/84.

and enhancing practices. The National Policy on Patient Safety Incident Reporting and Management has also been updated to include Covid-19 in line with other healthcare acquired infections.[115]

Escalating and responding to nosocomial transmission rates during the pandemic

90. During the pandemic the Welsh Government recognised the significant risk of nosocomial transmission. As set out above, the Nosocomial Transmission Group was established to draw together the necessary expertise to respond to this threat. On 15 November 2020, the Nosocomial Transmission Group noted that the hospital transmission rates in Wales were increasing. In the week ending 8 November 2020, probable or definite hospital acquired infections represented 3% of all cases diagnosed in Wales in that week and 50% of all cases diagnosed in hospitals. When considering the implications of this statistic it is important to note that the nosocomial transmission rate increased as community transmission increased. The highest number of hospital transmissions was in the Cwm Taf Morgannwg health board where the community transmission rate was also the highest and the number of people admitted to hospital was also the highest.

91. Professor Kloer confirmed that Glangwili Hospital experienced a series of nosocomial outbreaks between October 2020 and January 2021 and followed the Welsh Government's 16-point Outbreak Plan for Wales. Outbreak measures taken in response focused on *"the re-enforcement of the high standards needed around the use of PPE and the enhancement of cleaning services".* He emphasised that it should be remembered that at that time Covid incidence was rapidly increasing in the community and many individuals were infectious but asymptomatic: *"I think the experience of most hospitals is that when there's large community transmission there's also hospital transmission"*[116]

92. Properly used, PPE limits transmission between staff and patients but transmission was occurring between patients and between staff. The Nosocomial Transmission Group reported that transmission between staff was often because of a lack of social distancing in clinical areas: for example, in one health board 24% of staff were testing positive despite an approximately 1% community prevalence.[117]

[115] INQ000501402_12.
[116] Professor Philip Kloer, 30/164/25 - 30/165/3.
[117] INQ000396261_01.

93. Welsh Government messaging and the IPC guidance were consistent about the need for compliance and social distancing throughout the pandemic. The Welsh Government established an IPC sub-group in the Nosocomial Transmission Group, chaired by the Director of Nursing at Hywel Dda Health Board, whose membership included health and social care organisations and Health Education and Improvement in Wales. The IPC sub-group led on awareness raising, workforce IPC education, training and capacity.[118]

94. Following the Nosocomial Transmission Group briefing, on 11 December 2020, Dr Goodall wrote to all NHS bodies which detailed the *"range of measures I expect all health boards and trusts to prioritise and comply with in order to minimise the transmission of Covid-19 in our hospital settings."* This was accompanied by a document setting out the 'Key Standards for Environmental Cleanliness', a 'Specialist Estates Services Notification 20/23 Covid-19 and mitigating airborne transmission in healthcare settings' and reissued the June 2020 letter on bed spacing in healthcare settings.[119]

95. A crude comparison of the nosocomial transmission rates between waves ignores the effect of different variants which had different clinical impacts. The variants differed in their transmissibility and the prevailing circumstances in the community were very different bearing in mind the social distancing and NPI measures in place as well as the community transmission rates.

96. The incidence of nosocomial outbreaks was low in Cardiff and Vale University Health Board during the first wave but higher in the second. Its statement notes that *"guidance was issued about cohorting patients, but because of the lack of options due to UHW infrastructure, this led to an increase in nosocomial infections because of patients moving in and out of cohorts".* It also states that nosocomial infections increased in the second wave as more high consequence/urgent elective work was undertaken, along with the easing of lockdown measures which led to a rise in prevalence of Covid-19.

97. The Welsh Government accepts that by February 2021 *"minimising nosocomial transmission of COVID-19 [was] presenting an ongoing challenge for the NHS and care homes in Wales. The high level of community prevalence and the emergence of*

[118] INQ000396261_03.
[119] INQ000509263.

new more transmissible variants [made] it increasingly difficult to minimise spread in hospital and care home settings."[120] Hospital acquired infections represented 8% of all confirmed Covid-19 cases and 53% of all Covid-19 cases within Welsh hospitals. It was still the case that "*a significant proportion"* of transmission within hospitals was from staff to staff contact in non-clinical areas. As a result, Public Health Wales was commissioned to undertake a behavioural insights project.

98. In response to this briefing the Welsh Government continued to review, share and analyse the outbreak data submitted by local health boards, commissioned a peer review by the military of the IPC and nosocomial transmission policies, worked with NHS bodies on strengthening the local implementation and compliance with those policies through clinical leads.[121]

99. Comparisons between the devolved nations as a measure of success is obviously flawed. The experts emphasised that the differences may reflect the way in which different studies were conducted *"rather than a true reflection of the number of hospital-acquired infections in Wales."* They concluded that it was *"potentially true that there was a genuinely higher rate of hospital acquired infection in Wales."* Any difference may reflect the community-acquired infection rates across Wales which were lower in the first wave than in other parts of the UK, "*therefore the proportion of hospital acquired infections would appear larger…and there's probably a number of factors that could influence that."*[122]

The Learning Programme

100. In April 2022, the Welsh Government commissioned the National Nosocomial Covid-19 Programme to conduct investigations into patient safety incidents of nosocomial Covid-19 infections which occurred between March 2020 and April 2022. The final learning report was published in August 2024 and found *"examples of sub-standard care and areas for significant improvement, as well as areas of best practice that show examples of adaptability and innovation."*[123]

101. Notwithstanding the experts' warning set out above, the rate of nosocomial transmission was too high in Wales. The Welsh Government understands the

[120] INQ000227307.
[121] INQ000227307.
[122] Dr Ben Warne, 8/185/21 - 8/186/06.
[123] INQ000501402_23.

frustration of some bereaved families that the end of learning report could not provide a 'root cause' for nosocomial outbreaks during that time. However, the two-year programme investigated every one of the 18,360 individual cases of nosocomial Covid-19 infections that met the definition of a patient safety incident.

102. The Programme concluded that the aged NHS estate and limited isolation facilities meant that patients often could not be isolated and so cohorting was introduced to maintain operational flow during extreme demand. The inability to isolate patients meant that they were frequently moved around wards in an attempt to reduce spread of infections.[124] As indicated above, the challenges posed by bed-spacing and ventilation limited the ability to manage the risk of infection. There is room for improvement in the design of future healthcare settings: the pandemic highlighted the advantages of modern estate design, such as the availability of single rooms, for strengthening IPC[125]

8- Shielding

The effectiveness of the shielding policy

103. Professor Snooks questioned the overall effectiveness of the shielding policy given the absence of overall reductions in Covid-19 infection and an increased incidence of hospital acquired infection. Professor Snooks rightly accepted the limitations on her ability to reach firm conclusions imposed by the absence of high-quality and consistent evidence and she fairly accepted that the methodological difficulties faced by an epidemiological study.[126]

104. Professor Snooks' conclusion is unavoidably informed by hindsight. It was reached with the benefit of evidence, data and analysis that did not exist when the shielding programme was devised and implemented. The introduction of shielding was a groundbreaking step taken in response to SAGE's advice that it may "*delay the spread, modify the epidemic peak and reduce mortality rates.*"[127] The decision was not taken lightly because the Welsh Government anticipated the potential adverse effect of shielding on the emotional wellbeing of the clinically extremely vulnerable.[128]

---

[124] INQ000501402_20.
[125] INQ000501402_22.
[126] Professor Helen Snooks, 23/142/2-146/14
[127] INQ000485721/266.
[128] Sir Frank Atherton, 13/79/6-19.

105. Any assessment of the benefit of shielding must take a holistic view of the benefits provided to the clinically extremely vulnerable. It provided support through access to medicines, to food and other forms of support (including statutory sick pay) for those who would be better protected if they were shielded.

106. The Welsh Government's Integrated Impact assessment (dated 19 August 2020)[129] found that *"the most significant impact was positive"*. It found that the Welsh Government had established a robust system of governance for access to services and provisions to continue for those who were identified as clinically extremely vulnerable.

Identifying the clinically extremely vulnerable

107. The process of identifying the clinically extremely vulnerable was hampered by the absence of a single joint prescribing database similar to that in England.[130] The Welsh Government, therefore, had to undertake the complicated exercise of accessing and analysing 11 different datasets.[131] Not all of the information in those data sets was accurate or up-to-date.[132]

108. It is accepted that the IT systems in use in Wales would still be unable to identify a particular cohort of patients quickly should a similar shielding programme be necessary in the future. The Welsh Government is improving its patient data records and enhancing interoperability between different systems.[133] Digital Health and Care Wales was established in 2020 and is the national organisation building and designing digital services for health and care in Wales. Developing a national architecture and ensuring the interoperability of data systems across health and care is one of its key priorities.[134] Judith Paget acknowledged that data capture on NHS patient systems is not where it needs to be.[135]

---

[129] INQ000066205.
[130] INQ000485721/268.
[131] INQ000485721/269.
[132] Dr Andrew Goodall, 31/57/10-25.
[133] Sir Frank Atherton, 13/77/3 - 13/78/10.
[134] Sir Frank Atherton, 13/77/17-24.
[135] Judith Paget, 31/184/13-21.

The Welsh Government approach to pausing shielding

109. The Welsh Government's primary consideration was always the need to protect the clinically extremely vulnerable. When shielding advice was lifted in the summer of 2020 the Welsh Government took a different path to the UK Government.

110. On 31 July 2020, shielding was paused in the other nations and the advice from the CMO(W) was to do likewise. However, the Minister for Health and Social Services, having considered the views of the Disability Equality Forum that there had been insufficient warning of the change, decided to continue shielding until 16 August 2020. Although the Welsh Government accepts that the difference between the guidance and that of the UK Government may have caused confusion to some, the decision was motivated by a concern to avoid the clinically extremely vulnerable feeling abandoned by the lifting of shielding.[136]

9- DNACPRs

111. The evidence of members of the Bereaved Families for Justice Cymru about the inappropriate use of DNACPRs and DNACPRs applied without consultation is, on any view, profoundly distressing,[137] particularly because the Welsh Government was consistently clear that *"under no circumstance is a blanket approach [to DNACPRs] ever, ever appropriate."*[138]

112. A national clinical policy *"Sharing and Involving: A Clinical Policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales*" has been in place since February 2015. Its aim is to ensure a consistent approach to DNACPRs and it is regularly updated[139].

113. The Clinical Policy provides a decision-making framework for staff. It identifies clinical events that might act as a *"trigger"* for a team-based DNACPR discussion and its 'overriding principles' are clearly stated: ensuring that an individual's life is respected and valued; ensuring early senior clinical involvement and accountability in the decision-making process; and making clear that a DNACPR decision must not prejudice any other aspect of care. The responsibility for following this guidance lies with individual clinicians but the clinical policy has always been clear that an individual

[136] INQ000485721/100.
[137] Anna-Louise Marsh-Rees, 39/16/13-39/17/14.
[138] Professor Jean White, 6/137/16-23
[139] INQ000227411.

patient-centred approach is vital and all decisions should be based on individual circumstances.[140]

114. The Welsh Government also published *"Sharing and Involving — Information for patients and their carers to help make decisions about CPR (Cardiopulmonary Resuscitation)"* to make sure that patients and their carers could make informed decisions about resuscitation.[141]

115. The policy was updated in November 2020[142]. Although its core principles remained the same, it gave additional resources for patients and their loved ones and new detail about the All-Wales DNACPR form, how DNACPR discussions should be conducted and who should have them.

116. Where the Welsh Government became aware of the inappropriate DNACPRs, its response was unequivocal.

a. After concerns were raised with the Minister for Health and Social Services on 6 April 2020, the CMO(W) and CNO(W) wrote to all local health boards and other NHS bodies to say that the Welsh Government had established the Covid-19 Moral and Ethical Advisory Group and, in doing so, it had reiterated that patients should be consulted as much as possible about their care with adequate time for decision-making, especially around end-of-life care and DNACPR decisions.[143]

b. On 17 April 2020, the CMO(W) and CNO(W) sent another letter[144] to all local health boards on ethical decision-making. It clearly stated that *"age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes"*. They also stressed that decisions should be made on an individual basis and following consultation. The letter expressly said that the use of blanket DNACPRs was not acceptable.

[140] INQ000227411/5-6
[141] INQ000466416.
[142] INQ000283301.
[143] INQ000474252/132.
[144] INQ000300106.

c. On 10 March 2021, they wrote again[145] to re-iterate this position and said that *"it is unacceptable for advance care plans, with or without DNACPR form completion, to be applied to groups of people of any description".*

d. On 14 April 2022, in response to a report made to the Learning Disability Ministerial Advisory Group, another letter issued[146] to seek assurance that decisions were not being made *"purely on the basis of an individual's age, having a disability, learning disability, autism, mental illness or other condition*".

117. The evidence from the local health boards made clear that they were aware of, and fully understood, their responsibilities under this guidance.[147]

118. Neither Professor Merial Jenney nor Professor Stuart Walker,[148] from the University Hospital of Wales and Cardiff and Vale University Health Board respectively, were aware of *"evidence of inappropriate DNACPR decision making in those with protected characteristics during the course of the pandemic"*, Professor Kloer gave specific examples of inappropriate DNACPR notices.[149] That said, he also reported that the Hospital Director *"is not aware of an increase in DNACPR notices which did not appear to be clinically appropriate".*[150]

119. The Welsh Government has been clear that even one incident of an inappropriately applied DNACPR is too many.[151] Three reviews have been conducted into the use of DNACPRs in Wales:

a. HIW's *'Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wales'* (published in May 2024) reviewed approximately 280 DNACPR forms. Finding "*examples of noteworthy practice, but also areas needing improvement",* it made recommendations one of which was that the Welsh Government should consider the benefits of an all-Wales electronic patient repository for recording DNACPR decisions.[152]

---

[145] INQ000227370.
[146] INQ000412593
[147] See for example, INQ000480136.
[148] INQ000480136.
[149] INQ000475209.
[150] INQ000475209.
[151] INQ000412593.
[152] INQ000485929

b. '*The National Nosocomial Covid-19 Programme's End of Programme Learning Report*',[153] published in August 2024, considered the application of DNACPR decisions. It noted patients' concerns and identified the value of good communication and the importance of the continued development and implementation of an electronic advanced care planning document. It also stated that its analysis '*did not identify evidence or trends that DNACPR decisions had been placed inappropriately, or not in keeping with the current All-Wales DNACPR Policy*'.[154]

c. The NHS Wales Executive brought together bodies across the NHS in Wales leading to the publication of *'An All-Wales Thematic Review Learning Report: Mortality Review – Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)'*.[155] Organisations were required to review 4 cases each from January 2022 to January 2023, and the review highlighted key issues and presented actions to address these.

120. As it did during the pandemic, the Welsh Government will continue to work with the NHS in Wales to ensure healthcare professionals are supported to make effective DNACPR decisions. The Advance and Future Care Planning Strategic Group has considered the benefits of introducing the ReSPECT form. Having regard to the views of the Resuscitation Council UK, the group has concluded that it would improve the forms currently used.[156]

121. The Welsh Government recognises the potential value of an All-Wales electronic patient repository for recording DNACPR decisions. In the early 2025 Digital Health and Care Wales will work with stakeholders to assess which systems could best hold the necessary information. A National Peer Forum, to be established by the National Palliative and End of Life Care Programme in January 2025, will be asked to consider and agree a solution for the All-Wales repository and develop a business case by the end of the summer 2025.

[153] INQ000501402.
[154] INQ000471157
[155] INQ000514009.
[156] Judith Paget, 31/134/14 – 135/9.

10- Long Covid

122. The experts favoured the use of Long Covid Clinics because of their ability to contribute to the developing understanding/training about treatment for Long Covid and their role as a "one stop shop" for Long Covid sufferers.

123. However Long Covid care, as with all healthcare services in Wales, must be provided in a manner which works within and alongside existing services and structures in Wales. The NHS in Wales has therefore adopted a multi-professional, community-focused rehab model with the ability to refer people to specialists as required.[157] To provide the level of support required in the community for those impacted by Long Covid in Wales it was necessary to tailor care and support for people as close to their home as possible and to develop and invest in existing rehabilitation service delivered through primary and community care.

124. The Welsh Model for Long Covid care is right for the geography, population and NHS service provision within Wales.[158] The Welsh model is consistent with the broader strategic direction for the NHS, set under '*A Healthier Wales*' and the Strategic Programme for Primary Care. It was also thought that the service model adopted in Wales would benefit a broader range of individuals who were suffering from other long-term conditions such as ME and CFS and not only those suffering from Long Covid. The Welsh approach is consistent with Lord Darzi's recommended refocus of English NHS services away from hospital care and to the community.[159]

125. The Welsh model was designed by senior leaders, clinicians and service providers in Wales and it is consistent with NICE guidelines. People with Long Covid are able to access the majority of the services they need for assessment, diagnosis, treatment and rehabilitation support through existing primary and community care structures. In their report the experts accepted that the Welsh Model allowed for the upskilling of primary care in the treatment of Long Covid. The Inquiry's experts suggest that a possible disadvantage of the Welsh model is a disconnect with the secondary care support. That suggestion ignores the fact that the Welsh model allows and supports referral to specialist secondary care services, and studies show that only 3.5% of people required referral to those secondary care services.

---

[157] Judith Paget, 31/150/25-31/150/3.
[158] Judith Paget, 31/151/15-23.
[159] Independent Investigation of the National Health Service in England, September 2024.

126. The Welsh Government's All Wales Community Pathway for Long Covid provides clinical guidance on the management and treatment of long-Covid, including in what circumstances referral to more specialised services may be appropriate and details of the type of rehabilitation support which may be needed such as psychological support or fatigue and pain management. The aim of the Pathway is to inform and underpin local pathways to help to ensure a consistent approach is adopted in local health board areas.[160]

127. The Welsh model has been regularly reviewed and the results have been positive overall. In February 2022, a review into the Long Covid Adferiad Programme found that:

a. The number of people recorded as having Long Covid strongly correlated to the number of people referred to local health board Long Covid services, which indicated that patients treated in primary care were receiving Long Covid services.

b. The national patient evaluation showed patients participating in Long Covid services were reporting an improvement in their health.

c. The evaluation also showed that those receiving Long Covid services reported satisfaction with the quality of the experience of those services.

128. The report concluded that the Welsh model treating patients was effective in meeting the needs of the majority of those with Long Covid although it would benefit from refinements such as expanding capacity in community rehabilitation, recruitment of additional staff and continuing to learn about the best approaches to enable people to recover. The report also found value in integrating these services with those for people with other long-term conditions who also benefitted from a community-based rehabilitative service.[161]

129. There have been four evaluations of the service, most recently on 14 February 2023. 20% of those contacted for the evaluation rated the service as average or below average. The evaluation identified areas for improvement but it also found that the

[160] INQ000412547.
[161] INQ000474251/95-97.

majority of service users were satisfied with the services they received and 83% would recommend it to their friends.[162]

11- Non-Covid conditions

Essential Services

130. As set out above, it was necessary for the Welsh Government to provide a framework within which local health boards could make decisions to pause routine and elective care. That framework and the guidance issued during the pandemic explained the need to continue to provide essential services. *"Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential"* was published on 4 May 2020[163] and updated on 12 June 2020.[164]

131. The experts' conclusions about the difficulties providing cancer services during and after the pandemic are accepted. The Welsh Government supported local health boards by providing the following guidance:

a. *"Cancer Services in Wales during Covid-19"* published on 7 April 2020.[165]

b. To support the reinstatement of cancer services, the Wales Cancer Network published *"A Framework for the Reinstatement of Cancer Services in Wales during Covid-19"* in June 2020.

c. On 8 July 2020, Dr Goodall chaired a summit of senior NHS leaders to review the impact of the pandemic on cancer services and to agree next steps for recovery of cancer care.[166]

d. In March 2021, the Welsh Government published its post-pandemic approach to cancer in the "*Quality Statement for Cancer*"[167] and the National Clinical Framework.[168] Both were designed to guide the NHS in planning cancer services and they require an immediate focus on addressing waiting lists.

[162] Eluned Morgan, 35/159/18- 25/160/10.
[163] INQ000182443.
[164] INQ000486024/134
[165] INQ000399069.
[166] INQ000469033.
[167] INQ000469102.
[168] INQ000081910.

132. The waiting list for hip replacements has been categorised by the Inquiry's experts as "*absolutely huge*".[169] Save for where elective hip replacement surgery was clinically urgent, it was for local health boards to decide whether to provide elective surgery if it could be done safely and without compromising their ability to respond to Covid-19 patients and deliver essential services. The Welsh Government endorsed the use of NHS England's *"Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic"* (dated 11 April 2020),[170] under which more urgent surgery would been prioritised. This inevitably caused a marked decrease in the delivery of elective hip replacement surgery across Wales and particularly so in the early part of the pandemic.

133. The Welsh Government encouraged and expected local health boards to adopt a progressive approach to restoring services:

a. The Quarter 2 NHS Framework endorsed the *"Recovery of surgical services during and after Covid-19"* published by the Royal College of Surgeons.[171]

b. Dr Goodall and CMO(W) met the Welsh Orthopaedic Board on 27 May 2021 to discuss the development of an orthopaedic strategic programme for the aim of recovering orthopaedic services alongside any Covid-19 resurgence.[172]

c. In September 2021, the Welsh Orthopaedic Board, on behalf of the Welsh Government, commissioned the Welsh Orthopaedic Society to develop the National Clinical Strategy which established a plan for post-pandemic recovery published on 31 March 2022.[173]

134. In May 2021, Dr Andrew Goodall and the CMO(W) met with the Welsh Orthopaedic Board. Dr Goodall and the CMO(W) made it clear that the plans received from local health boards for recovery were not ambitious enough. This resulted in a National Clinical Strategy for Orthopaedics.[174]

135. Notwithstanding the requirements on NHS health bodies in Wales to continue to provide urgent cardiac services, the Welsh Government is aware that the response

[169] Professor Andrew Metcalfe, 24/71/1-5.
[170] INQ000226460.
[171] INQ000408892.
[172] INQ000469239.
[173] INQ000469236.
[174] INQ000485721/221.

to the Covid-19 pandemic had a major impact on all parts of the cardiovascular disease pathway – from a significant reduction in attendances for urgent and emergency care, deferral of diagnostic procedures and therapeutic interventions, reduced access to specialised care in the community and identification and management of risk factors for cardiovascular disease. In most of the district general hospitals in Wales, cardiologists were part of the front line Covid-19 response. In view of that, and at the earliest opportunity, the Welsh Government took steps to recover cardiac services alongside any Covid-19 resurgence. The Welsh Government took the following key steps to minimise this effect as far as possible:

a. Publication of the updated "*Guidance on Maintaining Essential Health Services during the Covid-19 Pandemic – summary of services deemed essential*" (dated 12 June 2020).[175]

b. Publication of the Essential Service Guide on Cardiac Specialised Services by the Welsh Health Specialised Services Committee on 7 May 2020.[176] It set out a proposed delivery approach for essential cardiac services through a co-ordinated staged approach.

c. On 22 March 2021, the Welsh Government published the Quality Statement for Heart Conditions which replaced the Heart Conditions Delivery Plan that was in place prior to the pandemic. It highlighted the immediate short-term focus on recovery and the medium- and longer-term potential for transform of cardiac services and set out 16 quality attributes of services for people with heart conditions in Wales.[177]

<u>The resumption of elective surgery</u>

136. The extent to which the delivery of routine services, including elective surgery, could be resumed was reviewed and described in the Quarterly Operating Frameworks but it was always a matter for local decision based on the local health boards' assessment of what could be done safely and without compromising their ability to treat Covid-19 patients and to provide essential services. Professional bodies, such

[175] INQ000182461.
[176] INQ000469211.
[177] INQ000469118.

as the Royal College of Surgeons, developed guidance and checklists to inform these decisions.[178]

137. Operational guidance about the safe return of routine arrangements was issued on 3 June 2020: it provided practical guidance about signage, communication with staff and visitors, social distancing, infection control measures.[179] Further guidance on 1 July 2020[180] set out the principles to be applied when reconfiguring premises to enable patients and staff to return safely and give people confidence when accessing services. It emphasised the importance of social distancing, face mask wearing, hand hygiene and good signage.

138. On 29 June 2020, Dr Goodall wrote to NHS Wales Chief Executives and Medical Directors outlining the need to reinstate some routine services to minimise the harm to patients and requiring that local health boards increase the provision of urgent diagnosis, treatment and care in order to avoid preventable mortality and morbidity.[181] Dr Goodall urged Local Health Boards to consider bold clinical innovation and service configuration issued with the possibility of extended hours of access into evenings and weekends to increase capacity, particularly where treatments may have longer term benefits.

139. On 19 November 2020, the Minister for Health and Social Services made a statement regarding the resumption of publication of NHS performance measures.[182] This noted that the Government has 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.

140. Throughout the pandemic the Welsh Government recognised that the extent to which routine or elective care could be safely provided would vary from hospital to hospital and between Local Health Boards. Professor Kloer described the difficulties confronting Local Health Boards when restarting elective services including difficulties caused by redeployed staff, insufficient capacity in local private hospitals, maintaining

[178] INQ000474252/04.
[179] INQ000299367.
[180] INQ00029943.
[181] INQ000469023.
[182] INQ000480727.

safe areas for procedures and an ever-growing backlog.[183] By comparison Cardiff and Vale University Health Board *"maintained the delivery of high consequence elective treatments (such as cardiac and cancer services) at the highest safe level possible"* and *"by late summer 2020…we were able to systematically provide surgical procedures…"*, with prioritisation of time-critical surgery and cancer surgery.[184]

141. Notwithstanding these efforts the Welsh Government could have applied greater pressure on local health boards to resume elective care earlier.[185] The Welsh Government's approach was generally permissive: it allowed the start of routine activity within the very first Quarterly Operating Framework of May 2020 but left it to local health boards to take the operational decision of what services to reintroduce services, how and when. Also, it is a defining feature of the Welsh healthcare system that it is not driven by financial incentives and so the resumption of elective surgery by means of such incentives was not appropriate.[186]

142. Consideration of the resumption of elective services should be tempered by the reality of the pandemic. Although the Quarterly Operating Frameworks of May, June and September 2020 rightly emphasised the need to reinstate elective and routine care, the policy was soon overtaken by further waves of the virus and winter pressures which inevitably stunted the sought-for progress.[187]

<u>The use of private hospitals</u>

143. Any comparison between waiting lists or the provision of surgery between Wales and England will need to be tempered by consideration of the difference in private sector capacity. Although NHS England was able to reduce approximately 18% of waiting lists by using the private sector, there are only 172 beds in the entire private sector in Wales. The NHS in Wales used what private sector capacity it was able to and it commissioned some private capacity in England.[188]

144. The extent to which private capacity could be used varied between local health boards. Professor Kloer confirmed that the private sector in West Wales is limited to a single hospital in Carmarthenshire which has 20 beds, two operating theatres and

[183] Professor Philip Kloer, 30/150/18-30/151/20.
[184] INQ000480136/3, INQ000480136/47
[185] Dr Andrew Goodall, 30/24/14-30/25/02.
[186] Eluned Morgan, 35/149/1-14.
[187] Vaughan Gething, 35/12/02-16.
[188] Eluned Morgan, 35/146/4-15.

three recovery bays. It did provide some support but had a limited effect.[189] Cardiff and Vale University Health Board did make referrals to the Spire hospital in Cardiff for elective treatment and/or investigation (with procedures *"staffed in part by [their] medical staff as Spire did not have the necessary operators"*), as well as some outpatient capacity.

12- The effect on healthcare workers

145. Health and social care workers were extraordinary in stepping up to respond to the huge range of challenges caused by Covid-19. Their dedication, commitment and professionalism was – and continues to be - to their credit and the Welsh Government once again would like to put its thanks and recognition on record.

146. Recognising the strain that health and social care workers were placed under, the Welsh Government encouraged local health boards and Trusts to ensure staff were supported. For example, the Welsh Health Circular issued by Dr Goodall on 30 October 2020 set out the Welsh Government's expectation that all organisations would support the health and wellbeing of their workforce through a package of support. It noted that the Welsh Government had worked closely with health and social care unions, employers and clinical colleagues to review support on offer in other sectors across the UK to help inform a multi-layered health and wellbeing support offer. It also set out an expectation that organisations would maintain up-to-date local webpages on staff health and wellbeing, and *"promote awareness of and encourage access to the national and local resources available"*.[190]

147. The Welsh Government recognises the national responsibility that support is not only in place but enhanced and targeted through this type of sustained event:

a. Between April and June 2020 the Planning and Response Group had a dedicated Health and Wellbeing Sub-group of the Workforce Deployment and Wellbeing Response Group which brought together individuals from NHS Wales, trade unions and the Welsh Government;[191]

b. The Health for Healthcare professionals scheme was expanded to provide an unprecedented level of support and advice to all healthcare professionals,

[189] Professor Philip Kloer, 30/151/6-8.
[190] INQ000355926.
[191] INQ000485721/242.

including doctors, nurses, healthcare professional students, paramedics, therapists, dentists and medical volunteers working in Wales during and post the Covid-19 pandemic. It provided a confidential helpline staffed by healthcare professionals, face-to-face counselling sessions and guided self-help tools and online resources. On 1 April 2022, it was rebranded as 'Canopi' to highlight that it now encompasses both the health and social care sectors.

c. Between August 2020 and August 2022, the Welsh Government funded a bespoke Samaritans helpline dedicated to NHS workers offering confidential support tailored for individuals working in health care settings, provided by trained volunteers who would be able to provide support outside of the workplace.[192]

d. A Welsh Government funded bonus payment for NHS and social care staff was agreed in March 2021.[193]

148. Dr Goodall, through the contemporaneous record in his Accountable Officer letters, emphasised that the Welsh Government will need to track NHS staff wellbeing for some years to come and many will need to come to terms with the impact of their personal and professional experience through the pandemic.[194]

13- Conclusion

149. It is not possible to summarise in only 40 pages the complexities of the effect of Covid-19 on the Welsh healthcare system. The Welsh Government has sought in its evidence and submissions to give a candid account of what it did and why and those measures which were effective and those which, with the benefit of hindsight, would have been done differently or not at all. Whatever view the Inquiry ultimately takes of the issues considered in Module 3, it is appropriate that the final words should be to recognise the selfless and humbling dedication of all those healthcare workers who, at great risk and cost to themselves, served the people of Wales.

[192] INQ000480081.
[193] INQ000485721/244.
[194] INQ000485721/9.