Witness Name: Judith Paget
Supplementary Statement: No. 1
M3/WGO/05
Exhibits: 3
Dated: 27 November 2024

UK COVID-19 INQUIRY

SUPPLEMENTARY WITNESS STATEMENT OF JUDITH PAGET

I, Judith Paget will say as follows: -

1. I provide this supplementary statement (M3/WGO/05) to a request made by the UK Covid-19 Public Inquiry following my oral evidence on 13 November 2024, providing further information on areas discussed during the hearing.

2. It is provided in addition to my two previous statements to Module 3, referenced M3-WGO-02 and M3-WGO-03.

<u>All-Wales electronic patient repository for DNACPR decisions</u>

3. The Healthcare Inspectorate Wales 'Review of Do Not Attempt Cardiopulmonary Resuscitation Decisions for Adults in Wales' was published on 23 May 2024 and is exhibited as **JPM3WGO05/001-INQ000485929**. Recommendation 15 stated the Welsh Government should consider the benefits of an all-Wales electronic patient repository for recording DNACPR decisions.

4. Ensuring electronic DNACPR status is signalled on patient records is complex. Responding to the recommendation requires the adaptation of an existing IT system in order to capture whether the patient had a DNACPR in place. In addition to developing the relevant software, and to adopt a Wales-wide approach and avoid the potential of duplicated records, the process requires the Welsh Government to develop guidance for healthcare professionals about how

and when the record should be completed and the actions required for reviewing the DNACPRs recorded.

5. The Welsh Government is commissioning Digital Health and Care Wales to work with stakeholders across health and social care in the early months of 2025 to assess which systems could hold the necessary information in order for recording DNACPR decisions to work safely across all care settings. The work will be led by the National Programme for Palliative Care and End of Life Care within the NHS Executive.

6. Decision-making in relation to DNACPR is a component of Advance and Future Care Planning. Conversations about what matters most when nearing the end of life take place between a patient and the clinician responsible for their care. The Advance and Future Care Planning Strategic Group – with membership including health boards, the Welsh Government and patient representation - provides direction for all aspects of advance and future care planning in Wales. It reports to the National Palliative and End of Life Care Programme.

7. A National Peer Forum will be established by the National Palliative and End of Life Care Programme in January 2025, including representation from clinicians and practitioners across health and social care who are supporting patients to consider advance future care planning in their day-to-day practice. Part of its work will be to consider and agree a solution for the All-Wales Digital DNACPR Repository and develop a business case by the end of the summer 2025.

8. In the meantime, we are working towards patients' DNACPR decisions along with their Advance and Future Care Plan being recorded on the Welsh Clinical Portal which will indicate to clinicians that a conversation has taken place with the person – and their significant others where indicated by that person – and clinicians should take this into account in their decision-making. The Welsh Clinical Portal gives NHS health professionals across the NHS, including both primary and secondary care, access to patients' digital health records in one place and we have instructed this change takes place with immediate effect.

Field hospitals

9. I was asked to share lessons of a review into field hospitals that was undertaken in March 2021. I exhibit that review as **JPM3WGO05/002-INQ000421690.** Its summary of findings outlined that:

    a. The predominant model in use across Wales was the step-down medically optimised model.

    b. The majority of patients reported positive outcomes for patients.

    c. The rate of transfers back to the acute setting had been low.

    d. Robust admission criteria, safety and governance processes had been implemented.

    e. Field hospitals had a significant impact on reducing the pressure on the NHS across Wales.

    f. There had been many lessons learned in relation to temporary surge capacity including the importance of clinical ownership and multi-professional induction.

    g. Having new teams in new clinical settings could be daunting.

    h. All health boards reported no issues with obtaining sufficient equipment.

    i. Workforce had been the main challenge and constraint to establishing large scale field hospital capacity.

    j. The majority of health boards could see a future for field hospitals.

    k. Health boards reported early engagement with the Welsh Ambulance Service and had developed strong working relationships.

All-Wales thematic review on DNACPR

10. Further to questions from the Disability Charities Consortium, I exhibit 'An All-Wales Thematic Review Learning Report: Mortality Review - Do Not Attempt Cardiopulmonary Resuscitation' as **JPM3WGO05/003-INQ000514009.**

11. The review presents the key issues found and the actions to address these, with recommendations ranging from minor organisational arrangements, structural and strategic reorganisation, through to significant all-Wales changes.

Statement of Truth

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

Signed: Personal Data

Dated: 27 November 2024