

Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales: Report 1

July 2020



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July 2020



About the Committee

The Committee was established on 28 June 2016. Its remit can be found at:
www.senedd.wales/SeneddHealth

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Chair's foreword



In 1854, faced with a cholera epidemic in Soho that killed 500 people in 10 days, Dr. John Snow identified and traced the addresses of the people who died on a detailed street plan. From this, he identified the Broad Street water pump as the source of the epidemic. Long before the discovery of viruses and bacteria, Dr. Snow's contact tracing neutralised the contagion.

This innovation forms the basis of public health interventions to this day; interventions that find themselves in the spotlight once again in the fight against the contagion currently plaguing almost every country in the world – Covid-19.

The onset of this coronavirus changed the world forever. Pandemic preparedness, long neglected, suddenly became pivotal, as did the importance of public health, again a long-neglected discipline.

In our hospitals and care homes, there was a palpable sense of fear amongst staff who were all too aware of the effects of Covid-19, but who battled on in the most difficult of circumstances.

In those early days, and in the days that have followed, society discovered who the true key workers were. Health and social care staff have been heroic in their response to this pandemic. Under the most extreme pressures, they have shown an unwavering determination to tackle the extraordinary challenges presented by the virus. Sadly, for some, this cost them their lives.

This has, of course, been an epic team effort, involving public health officials, all key workers and unpaid carers. Local authorities have moved mountains to protect and support the most vulnerable. Within our communities, huge number of volunteers have mobilised, doing everything from distributing food and medicines to making scrubs, gowns and masks. The public has also played its part, sacrificing contact with family and friends in the interests of the greater good.

Covid-19 has been cruel and ruthless. At the time of writing this, more than 10 million people have been infected worldwide and, in the UK, over 43, 000 people have tragically died, more than 1500 of those in Wales. While there have been discussions and disagreements about how best to tackle the virus, we cannot and should not forget that behind those figures was someone's mother, son, daughter,

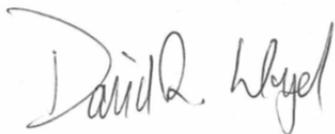
father. We must do everything we can to prevent the events of the last four months from happening again – that is the main purpose of this report.

That is not to say that there will not be further spikes or more localised outbreaks of infection, but our focus must be to avoid a second wave of the kind that we have already seen, that took so many lives. Governments across the UK will need a focused and sustained approach to suppressing the R-number, and will need to demonstrate agility in their respective responses, mindful always that Covid-19 is like SARS, not like flu.

There are serious challenges ahead, and we need to ensure that measures are in place – a resilient supply of appropriate personal protective equipment; ready access to testing with swift turnaround times for results; and a fully functioning contact tracing system. These are the tools that give us the best chance of success against the virus.

The shock of Covid-19 has been so severe, it has shaken our very foundations. Yet, it gives us the chance to reset our course for the future. We can rethink how we support our vital yet fragile social care sector, and re-assess our approach to mental health, bringing services in line with those for physical health. This is the time to be radical, and significant changes for the better can be achieved if we grasp this opportunity. Further Health Committee reports will address these issues in detail.

The diligence and dedication of people like Dr. Snow in Victorian times has shown us how an unseen killer disease with no known treatment can be eliminated. In the 21st Century, we need the capacity and organisation to achieve the same end.

A handwritten signature in black ink that reads "David Lloyd". The signature is written in a cursive, flowing style.

Dr. Dai Lloyd MS
Chair

Recommendations

Recommendation 1. The Welsh Government must, as a matter of urgency:

- publish a strategy for securing a resilient supply of PPE;
- stockpile appropriate PPE in sufficient quantities for any future outbreak;
- keep under review the PPE it has stockpiled to ensure that it remains of adequate quality and is fit for purpose, including that the design and fit is appropriate for all wearers and suitable for staff, patients or carers who are deaf or hearing impaired;
- publish a strategy for ensuring resilience of distribution arrangements for PPE;
- work with partners to ensure that guidance on PPE is kept up to date in the light of the most recent scientific advice, and communicate this advice clearly to staff. Page 30

Recommendation 2. The Welsh Government must review its own systems to ensure the mechanisms are in place to enable manufacturers in Wales to respond quickly in supplying appropriate PPE in the event of any future outbreaks. This must include having procurement arrangements that are able to respond in a timely manner..... Page 31

Recommendation 3. The Welsh Government must ensure that third sector organisations providing vital care services have reliable access to appropriate PPE. Page 31

Recommendation 4. The Welsh Government, and its partners, must ensure that there is local access to testing for anyone who needs it, as and when they need it. GPs and primary care need to be an integral part of these arrangements. Page 40

Recommendation 5. The Welsh Government, working with its partners, must ensure an ongoing campaign of clear, consistent and repeated public messaging – at a national and local level – about when to seek a test for Covid-19 and how to do this. Page 41

Recommendation 6. The Welsh Government should ensure there is similarly clear and consistent messaging about the value of testing, not only in identifying people with the virus but to assist in research and development of future solutions..... Page 41

Recommendation 7. The Welsh Government, working with NHS Wales, must develop a clear plan for regular and repeated testing of health and social care staff, including asymptomatic staff..... Page 41

Recommendation 8. Given the concerns about a future second spike of infection, the Welsh Government, working with its partners, should assess the likely future demand for testing and take steps to ensure there is sufficient capacity so that anyone who needs a test will be able to access one quickly and easily. As part of this, the Welsh Government and partners must remain alive to the development of different types of testing models..... Page 41

Recommendation 9. The Welsh Government must ensure that all patients being discharged from hospital directly into a care home have been tested in accordance with latest best practice to ensure maximum protection for residents and staff..... Page 42

Recommendation 10. The Welsh Government must ensure that:

- testing within care homes takes place on a regular and systematic basis,
- such tests are administered by suitably trained individuals rather than using home testing kits and
- sufficient capacity is available to support both of the above. Page 43

Recommendation 11. The Welsh Government must take steps to:

- ensure there are no further breaches of patient data going forward, and
- better communicate with people who have been advised to shield. This needs a clear, well-structured, responsive, timely and transparent approach, and must be an integral part of the future strategy for support to this very vulnerable group of individuals. Page 52

Recommendation 12. The Welsh Government must re-examine the arrangements with major supermarkets to ensure it can satisfy itself that there will be sufficient capacity for online food shopping and home delivery to meet demand, particularly during the coming winter period. Page 52

Recommendation 13. The Committee recognises that there is a cohort of people not on the shielded patients list who are otherwise vulnerable or normally rely on online food shopping and delivery services. The Welsh Government must look at how best to identify and offer support to these people..... Page 52

Recommendation 14. The Welsh Government should commission a focused and rapid review of the current arrangements for delivery of medicines to ensure they are robust, reliable, safe and sustainable, and able to meet both current demands and potential future pressures, especially during the winter months..... Page 52

Recommendation 15. The Welsh Government must work in partnership with local authorities to review existing support arrangements for shielded people, and implement improvements as necessary..... Page 53

Recommendation 16. The Welsh Government must ensure that there is clear guidance made available to those who are shielding about accessing routine healthcare services and how to do this safely. Page 53

Recommendation 17. The Welsh Government must ensure there is clear guidance provided for families and carers of people who are shielding about returning to work, and the support they can expect. Page 53

Recommendation 18. The Welsh Government must take the opportunity now to review all arrangements to ensure that the scale of the infrastructure, the technological rollout and the necessary recruitment exercises are in place to ensure an efficient and effectively functioning contact tracing system. The system must not be compromised because of a lack of planning, resources or technology, when there has been time to prepare and important opportunities for learning. Page 70

Recommendation 19. The Welsh Government, working with Public Health Wales, must aim for all test results to be returned within 24 hours..... Page 71

Recommendation 20. The Welsh Government should move immediately to a system where contact tracing begins either on receipt of a positive test, or within 24 hours..... Page 72

Recommendation 21. The Welsh Government must ensure there are systems in place to both monitor effectively the false negative rate, and to ensure testing is delivered responsively and flexibly to minimise the false negative rate..... Page 72

Recommendation 22. In consultation with Public Health Wales, the Welsh Government should:

- publish a strategy to increase the number of people presenting for tests in order to utilise more fully the available testing capacity;
- take steps now to provide assurances that 20,000 tests per day will be able to be delivered;
- ensure that safeguards are in place to guarantee that capacity from facilities outside Wales is fit for purpose and sufficient to meet demand.
- ensure that the system is able to respond to increases in demand, and expand to meet these. Page 73

Recommendation 23. The Welsh Government must, as a matter of urgency review its decisions about the number of staff needed for contact tracing in order to assure itself and the public that the system will be able to function effectively at times of highest demand, and can flex and respond according to changes in demand. It should publish the results of the review. Page 74

Recommendation 24. The Welsh Government must confirm, as a matter of priority, the financial support package for local authorities to support the employment of professional tracers, rather than depend on redeployment of existing staff..... Page 74

Recommendation 25. The Welsh Government, working with its partners, must ensure a system of clear and repeated public messaging – at a national and local level - about individual responsibilities to self-isolate on symptoms, and the importance of urgent self-referral for testing..... Page 74

Recommendation 26. The Welsh Government must pursue with the UK Government the arrangements for statutory sick pay for social care workers in Wales required to self-isolate. This should be done urgently..... Page 75

Recommendation 27. The Welsh Government must provide further information about the protocol on cross-border arrangements..... Page 75

Recommendation 28. The Welsh Government must, as a matter of urgency, put in place a short-term, guaranteed funding commitment to support adult social care services to mitigate the financial impact of Covid-19. This commitment must be developed in consultation with service providers, including local government. Page 81

1. General Conclusions

- 1.** The scale of the challenge facing governments and their partners in dealing with the effects of Covid-19 has been unprecedented. Enormous efforts have been made across the board, resulting in many significant achievements.
- 2.** The work of staff across all sectors involved in responding to the crisis must be commended; none more so than those in health and social care. They have transformed services and developed new arrangements and procedures in a very short period of time. They have shown enormous commitment and dedication in the most difficult of circumstances to ensure that those in need of their help could receive it. For many, this has meant making considerable personal sacrifices, such as living apart from their families for extended periods in order to continue to provide care safely to others.
- 3.** The general public has also made huge sacrifices, and these deserve to be recognised. Families and friends have been separated, and the most vulnerable have been isolated from their wider support networks. Their collective efforts in adhering to the lockdown rules have significantly suppressed the spread of the virus; however, its effects will continue to be felt in our communities for some time to come.
- 4.** Tragically, there have been over 1500 deaths in Wales involving Covid-19. Our deepest sympathies go out to the families and friends of those who have lost loved ones.
- 5.** Over the course of the last five months, there have been many hard lessons. The outbreak exposed serious weaknesses that existed in many areas, including our production and acquisition arrangements for personal protective equipment, our set-up for testing, our critical care capacity and our ability to protect our older people living in care homes.
- 6.** It is only right that future actions, including any decisions on further periods of lockdown, must be both taken and judged on the basis of the knowledge acquired during this time. The Welsh Government and its partners have a wealth of hard-fought experience to draw on as we move forward into the next phase of managing the outbreak.
- 7.** A second wave does not have to be inevitable if the lessons of the last few months are properly learned and fully applied.

- 8.** That is not to say that there will not need to be measures to manage the virus. There may be spikes, and the need for localised measures to manage these. And, of course, we are largely dependent on the actions of the public in accepting their individual social responsibilities. But governments must do everything in their power to ensure that we do not experience a second wave on the same or similar scale to the first.
- 9.** We must take this opportunity to be better prepared, on all fronts, for the challenges ahead, especially during the coming winter period.
- 10.** In particular, and to avoid the need for a second lockdown, it is vital that we have an efficient and effective contact tracing system in full operation. Linked to this is the need to ensure that our care homes are properly supported and fully protected. This matter will require close monitoring and the ability to respond quickly to changes in infection rates in the population.
- 11.** It will also be crucial to quickly replenish stocks of PPE that have been all but exhausted during the current crisis, as well as ensure a resilient future supply. In doing so, the experiences of the last few months must be acted upon to reduce our reliance on overseas imports and to ensure that the design and fit of PPE is suitable for all those who need to wear it, and those who are deaf or hearing impaired. It must also be regularly reviewed to ensure it is kept up-to-date and remains safe to use.
- 12.** Our pandemic preparation should be better able to flex to meet demand for high numbers of hospital/critical care admissions. Future planning must take full account of this, as well as ensuring that a certain amount of routine services can continue to be offered alongside those required in a national emergency.
- 13.** Linked to this, it will be imperative not to continue to run the critical care system, and overall bed complement, so 'hot' in the future, with bed occupancy levels in excess of 85 per cent. Instead, there is a need to ensure that there continues to be additional capacity, in terms of staffing, beds and equipment, to respond to future spikes in demand.
- 14.** More broadly, the outbreak has reminded us of the need to re-establish the primacy of public health. This has been in steady decline for many years, having been side-lined by a number of other matters, including complacency by governments about the likelihood of outbreaks of infectious diseases, as well as public spending restrictions.
- 15.** Turning from health to social care, the ongoing fragility of the social care sector and the need for a longer term solution is well documented. Despite the

crucial role played by the sector, there continues to be a lack of joined up working with the NHS, and a pressing need for better integration of the two services as well as proper recognition for social care staff in their terms and conditions. We will consider this further in future reports.

16. Finally, there will be a need to support those who have experienced trauma as a result of the outbreak, and those with ongoing mental health conditions. Many of these people will not have been able to access their routine services for some time and this will have significant implications for their ongoing health and wellbeing, and for the health service. Again, this will be the subject of future reporting.

This report

17. This is the first report in a series and focuses on a number of key areas, namely personal protective equipment; testing; shielding of vulnerable people; the Test, Trace, Protect Strategy; and financial implications for local government. We have chosen to focus on these areas initially because they reflect the areas in which there were the most pressing concerns and need to make progress quickly.

18. Future reports will consider matters that are equally important, but that we have not yet had the opportunity to consider in detail, including easing restrictions; exit strategy; returning to 'normal services' in the NHS and care sector; the future demand for rehabilitation; mental health services; impacts on unpaid carers; and data and the use of technology.

19. The purpose of this report is to inform short and medium term planning.

20. It is not meant to be a detailed examination of the decisions that have been made. These will inevitably be the subject of any future public inquiry.

2. Introduction

Covid-19

- 21.** Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV). A novel coronavirus (nCoV) is a new strain that has not previously been identified in humans.
- 22.** A pneumonia of unknown cause detected in Wuhan, China was first reported to the World Health Organisation (WHO) Country Office in China on 31 December 2019. The outbreak was declared a Public Health Emergency of International Concern on 30 January 2020. On WHO named the syndrome caused by this novel coronavirus: Covid-19.
- 23.** The 2019–20 coronavirus outbreak was confirmed to have spread to the UK on 31 January 2020 when the first two cases with the respiratory disease Covid-19 were confirmed in Newcastle upon Tyne.
- 24.** The first case of coronavirus in Wales was confirmed on 2 March 2020.
- 25.** Scientific and medical experts in the UK began considering the potential impact of Covid-19 in January. On the 11 February, the Welsh Government Chief Scientific Adviser for Health began joining the bi-weekly Scientific Advisory Group for Emergencies (SAGE) meetings and briefing the Chief Medical Officer for Wales (CMO) and the Health Protection Team in the Health and Social Services Group, Welsh Government.
- 26.** On 27 February, the Welsh Government established a Technical Advisory Cell (TAC)¹, co-chaired by the Chief Scientific Adviser for Health. Membership includes experts from the Welsh Government and Public Health Wales (PHW).²

¹ TAC is the core team of public servants who: take active part in UK-wide COVID-19 scientific groups such as SAGE; Chair and run TAG and its associated sub-groups; draft and issue advice to the Welsh public sector and communicating advice and evidence on COVID-19 to the wider public as needed. TAG is the Technical Advisory Group: the group of scientific and technical experts who provide advice and guidance to the Welsh Government in response to COVID-19.

² <https://business.senedd.wales/documents/s100082/Paper%201%20-%20Welsh%20Government.pdf>

Timeline of key events

27. A detailed timeline of the Welsh and UK governments' response is provided in the [Senedd Research blog](#). A shortened version has been appended to this report. It focuses on the key health and social care events up to and including 29 June.

The Committee's inquiry

28. In mid-March 2020, the Committee agreed to pause all business not directly related to Covid-19, and to undertake an inquiry into the impact of the outbreak, and its management, on health and social care in Wales.

29. As part of this, the Committee will examine the response by the Welsh Government and relevant public bodies, as well as considering the impact on staff, patients and others receiving care or treatment in both clinical settings and the community. It will also consider the Wales response in the wider, UK context.

30. The Committee has issued an open call for evidence and is also conducting a survey to better understand the challenges for those working on the frontline, and those whose health or care needs have been directly, or indirectly, affected by Covid-19

31. In addition to inviting [views in writing](#), the Committee has agreed a [programme of virtual oral evidence gathering](#), and will publish a series of reports setting out its findings.

32. Unless otherwise stated, all figures included in this report are the latest available at the time of publication.

3. Personal Protective Equipment (PPE)

33. Personal Protective Equipment (PPE) is designed to help protect an individual against health or safety risks at work and prevent the spread of infection. In health and social care settings, PPE includes a wide range of items, including protection for eyes and face, gloves, aprons and gowns, and respiratory protective equipment, such as masks or face shields. Different types of PPE are used, according to the level of risk, the setting or the procedure being carried out. PPE is essential in ensuring a safe environment for the care of people with coronavirus and avoiding infection for those giving and receiving care.

34. In Wales, the distribution of PPE is co-ordinated by the NHS Wales Shared Services Partnership, working with the Joint Equipment Stores that service local authorities.

Guidance on PPE

35. Guidance on PPE has been agreed jointly between the four UK nations, and is set out on the [UK-wide Covid-19 PPE hub](#), which includes recommendations on the use of PPE for hospital, primary care, community and social care settings, as well as for paramedics. The guidance also covers how long PPE should be used for and when it should be replaced.

36. According to the WLGA, the publication of this updated guidance on 2 April, and subsequent additional information from Public Health Wales which clearly set out detailed guidance on the appropriate and required level of PPE to be used by social care in specific settings, was important in clarifying the use of PPE by social care staff and increasing understanding of what was required.³

37. However, Care Forum Wales told us that the changes to the guidance had caused some confusion in the care home sector. Firstly, because some local authorities had acted on it immediately, while others had taken a week or more to implement it:

“we were getting members contacting us saying the local authority was saying they’re not supplying this because it’s not the guidance, whereas, actually, we were saying, [] this new guidance, issued on an

³ Written evidence, C26

all-UK basis by the four nations, was issued last week, and this is what they should be doing.”⁴

38. And secondly, because there were different requirements for the PPE to be worn by care home staff and visiting health professionals, which had caused some confusion and upset amongst residents.

Supplies of PPE

39. There has been considerable and widely reported concern in the UK and worldwide regarding securing adequate and continuous supplies of PPE. In a Welsh Government [coronavirus briefing on 21 April](#), the Minister for Health and Social Services stated that there were “very real concerns” about the issue in government, with the PPE challenge as his top priority and that although Wales had:

“...enough of stocks of all items to last for a few days, partly because of the mutual aid we received from other UK countries, partly because of the UK supplies that have come in that we’ve got our population share from. But we’re not in a position to say that we have weeks and weeks of advanced stock on all of those items.”

40. In evidence to this Committee on 30 April, the Minister again stressed that demand was likely to remain well above normal, but there was enough PPE within the system. He went on to say:

“this is an area where we have made real progress over the last few weeks, but it’s not something that I am in any way complacent about or see as a done deal. It’s still my No. 1 anxiety about keeping staff safe.”⁵

41. He went on to say:

“We’re going to use PPE at a much greater rate across health and social care for a long time, so for a long time we’ll need to both procure and manufacture our own PPE in different measures, and we then need to think, as we come towards the end of this extraordinary period of time, of what the balance should be for the future in having a robust and sustainable approach to PPE provision that involves the balancing of

⁴ RoP, 7 May 2020, paragraph 264

⁵ RoP, 30 April 2020, paragraph 233

international procurement and then home provision and home manufacture.”⁶

42. In an update to this Committee on 4 June, the Minister told us:

“So, we think we are in a much better position. This was my biggest anxiety for some time, as you know, and we came within having days of supplies of some items, rather than weeks. We’re now in a position where we think we do have months of supply across most of our items. There’s an issue about eye protectors—they’re not in quite the same position, but we still have enough—and we’re not in a position where we think that that supply chain is at a point where we should be worried about it immediately.”⁷

43. He went on to say that he was working closing with the other UK nations:

“We’re all trying to pursue our own deliveries as well as working collaboratively around UK procurement, because we need to make sure that we’re not closing off any of our routes to market and supply chains, because the position could change, and I do not want to see us go back to the position that we were in in March and April. So, that means longer term manufacture for PPE, not just a few months, from companies in Wales and the rest of Britain, and it means getting ready for the fact that we may see further stress come onto our supply chains in the future. And easing out of lockdown is one of the factors where more PPE could be used.”⁸

Procurement and manufacturing

44. Wales and the UK have traditionally relied strongly on supplies from China and other Asian countries.

45. In a [briefing](#) on 27 April, the First Minister advised that the Welsh Government was not relying simply on established links, but taking a multi-pronged approach to ensuring sustainable PPE supplies, including:

- Working with other UK nations to pool procurement efforts, bring in new stocks and offer mutual aid in providing PPE;

⁶ RoP, 30 April 2020, paragraph 236

⁷ RoP, 4 June 2020, paragraph 81

⁸ RoP, 4 June 2020, paragraph 84

- Procuring additional PPE supplies using the Welsh National Procurement Service;
- Continued international supplies, including masks from China and gowns from Cambodia;
- Increased working with Welsh businesses through innovation and new manufacturing routes, to produce PPE including faceshields and scrubs, with Wales approaching self-sufficiency in the latter.

46. Around 90 per cent of Wales’ PPE supplies are still coming from abroad, although the Welsh Government has been actively supporting more domestic production. In this Committee on 30 April, the Minister for Health and Social Services told us:

“we’ve had more companies that are coming online making items, from the early stage about hand sanitiser and eye protection equipment—we’ve got quite a number of Welsh firms doing that now. (...) We should be self-sufficient, I think, on scrubs this week. And we’re also then looking at the potential for fluid-resistant gowns to be produced here as well.”⁹

47. In an update published on 19 May, the Welsh Government said:

“We cannot simply rely on supplies from overseas – we have to have develop a home-grown supply of essential equipment. We want to support manufacturers in Wales, to keep us safe and to keep our communities strong, and we’re looking at how we can make more of the PPE we need closer to home.

We have been struck by the level of innovation and support offered from all parts of Wales to develop more PPE and new technology to tackle the outbreak. We have had around 1,000 enquiries and offers of support from manufacturers to date, half of these have been about PPE or medtech.

We are already working with many Welsh businesses, which have offered their help and expertise to make PPE and other essential equipment for the NHS, including hand sanitiser.

⁹ RoP, 30 April 2020, paragraph 235

For the first time, we are self-sufficient in scrubs in Wales – we’re making 5,000 a week, bringing back overseas jobs and anchoring them in the Welsh economy.”¹⁰

Availability of PPE

48. Much of the early evidence we received reflected the fears and concerns of frontline staff about the availability of appropriate PPE.

49. A survey¹¹ carried out by the BMA between 28 and 30 April found that 67 per cent of doctors in Wales did not feel fully protected from Covid-19 at work, and 60 per cent had had to purchase items of PPE directly, or had received supplies as an external donation due to non-availability of official NHS procurement supplies.

50. The RCN reported a high volume of calls in March from members across Wales distressed at their lack of access to PPE, notably from community nursing teams. It said that 74 per cent of nursing staff had raised concerns about PPE, with over half (53.8 per cent) having felt pressured to care for a patient without adequate protection.¹²

51. Similar concerns were raised in evidence submitted by the Royal College of Physicians¹³, Chartered Society of Physiotherapy¹⁴, Royal College of Surgeons¹⁵, and the Royal College of Psychiatrists.¹⁶

52. The Royal College of GPs told us that, initially, they had been informed that there was no provision planned for GPs. While this position rapidly evolved, the initial supply was patchy, poorly communicated and lacked clarity over the proper use of equipment.¹⁷ However, at our meeting on 14 May, Dr Rob Morgan told us:

“I do think we’re in a better position now, and I think we as GPs feel a little bit more reassured by the fact that we do have reassurances of supply chains and that PPE isn’t likely to run out. (...) those early days were quite scary for us on the front line, and particularly at the point

¹⁰ [Coronavirus and personal protective equipment \(PPE\)](#) – 19 May 2020

¹¹ [BMA press release](#) – 3 May 2020

¹² Written evidence, C05

¹³ Written evidence, C08

¹⁴ Written evidence, C12

¹⁵ Written evidence, C22

¹⁶ Written evidence, C31

¹⁷ Written evidence, C03

where it was clear that this condition (...) was likely to hit the community quite quickly.”¹⁸

53. The Medical Protection Society were concerned that, if a doctor were to decide they could not safely see a Covid-19 patient because of a lack of adequate PPE, and that patient subsequently came to harm, the doctor should not be held personally accountable by their employer or the regulator. It called on the Welsh Government to endorse its position that doctors across NHS Wales should not be subjected to regulatory or disciplinary action following a decision or outcome that is the result of poor PPE provision.¹⁹

54. In relation to provision of PPE for pharmacies, we heard from Community Pharmacy Wales that “despite the real support shown by Welsh Government to the pharmacy network” this is one of the only areas in which they really feel let down and left to find their own sources of PPE. Mark Griffiths told us:

“we received supplies very early on (...) from the health board, which was really good. But, as the time has gone on, there have been issues with regard to getting hold of PPE. So, I would say it’s a mixed bag with PPE with regard to pharmacy.”²⁰

55. The Royal Pharmaceutical Society however “welcomed and congratulated” the Welsh Government for its response in ensuring PPE equipment was supplied to pharmacy teams at an early stage, saying:

“We were pleased that PPE was distributed rapidly to all 715 community pharmacies in Wales. Feedback from our members suggests that, generally, the standard of PPE and the speed of its distribution to pharmacy teams has met need.”²¹

56. Written evidence from Aneurin Bevan UHB²² noted that the UHB felt the management and supply of PPE had been effective, with any risks well managed through escalation processes. Dr Sarah Aitken told us:

“the issue with PPE was the quantity that was needed very quickly and the need to put in place a supply chain that could manage that

¹⁸ RoP, 14 May 2020, paragraph 51

¹⁹ Written evidence, C07

²⁰ RoP, 14 May 2020, paragraph 174

²¹ Written evidence, C21

²² Health, Social Care & Sport Committee, 21 May 2020, Paper 1

quantity from sourcing it at Government level through to distributing it to every single frontline worker. The military have been incredibly helpful in terms of understanding that end-to-end supply chain, and in terms of the hospital, we have always had sufficient PPE in our hospitals and we've now got good flow through to every ward."²³

57. Dr Chris Stockport reported a similar situation in the Betsi Cadwaladr UHB area:

"we set up within the first few weeks a PPE cell and took in support from our military liaison colleagues in terms of help to distribute equipment more quickly and to move it around north Wales, and that's worked well. I'd say that, at the moment, we're in a position where our PPE supplies are more predictable. Certainly, looking at the stocks that we're holding at the moment, we have stocks across all of our equipment."²⁴

58. We have heard from a number of witnesses, including the RCGP and RCN, that although the position has improved in terms of PPE supply and availability, they would continue to seek re-assurance on the continuity of PPE supplies, particularly once current lockdown arrangements are eased. Similarly, the Royal College of Emergency Medicine said that:

"Frontline staff are grateful for the PPE that has been made available to them to date, but the ongoing supply continues to be a worry, and the fear remains that a significant surge in demand (...) could stress the supply chain."²⁵

59. The Royal College of Surgeons told us that, before resuming surgical services, hospitals should be satisfied they have adequate PPE and surgical supplies appropriate to the number and type of procedures performed, and clear policies on how and when to use them.²⁶

²³ RoP, 21 May 2020, paragraph 214

²⁴ RoP, 21 May 2020, paragraph 217

²⁵ Written evidence, C37

²⁶ Written evidence, C22

Design and fit of PPE

60. Evidence from the Royal College of Physicians raised concerns around the fit of PPE, saying:

“PPE is only effective when it is properly fitted, so it is concerning to see that 21% [of its members] either had not been fit tested or were unable to access fit testing for their PPE. (...) Fit testing and fit checking must take place to properly protect staff.”²⁷

61. It went on to say that fit testing was even more important if masks were being reused, and the College had been encouraging its members to have a PPE partner when donning and doffing to ensure that this was done correctly to minimise risk.

62. It also highlighted the additional problems being faced by women trying to get a secure fit for their PPE masks:

“Despite the high proportion of female clinicians working in the NHS, PPE masks are largely designed for male frames. One RCP member told us that they only passed fit testing when the mask was tied very tightly – something that they worried might not be replicable in an emergency situation.”²⁸

63. The Welsh Ambulance Services NHS Trust told us that training and communication had been key, including supporting staff with training on the use of PPE and being clear about the levels required in differing clinical scenarios:

“Fit testing, a process of assessment of a staff member in use of a filtered face piece (FFP3) mask, has been of equal importance, as it is critical that staff achieve a “fit” in each type of mask provided, to ensure their safe use in the operational setting.”²⁹

64. Evidence from the National Deaf Children’s Society and the Royal College of Physicians highlighted the problems that opaque PPE masks present for healthcare workers, patients and carers who are deaf or suffer from hearing loss:

“We understand the need for PPE in health settings to mitigate risks of the virus and keep people safe, but we are concerned that this does

²⁷ Written evidence, C08

²⁸ Written evidence, C08

²⁹ Written evidence, C41

present communication barriers for deaf patients and for deaf members of staff.”³⁰

65. The Royal College of Physicians reported that hoods with respirators which were transparent had been used with positive feedback from both wearers and patients in some hospitals. It suggested that the Welsh Government procurement teams should seek to expand the selection of PPE equipment being purchased with the aim of ensuring that all members of the NHS workforce have the PPE that they need.

Supplying the social care sector

Residential care

66. According to the Welsh Government, all social care settings have received regular deliveries of free PPE from the Welsh central and pandemic stores to supplement their regular supplies of PPE. It says that “as of 24 April, almost 12 million items of PPE have been distributed to all local authority joint stores for onward distribution to social care settings in Wales”.³¹

67. However, evidence from the GMB Trade Union suggests that “the majority of employers were not adequately prepared for the COVID outbreak”. It went on to say:

“GMB members working in the sector were terrified that the only provision that they were being provided with to deal with the COVID outbreak were gloves and plastic aprons, this was woefully inadequate and GMB believed that this left the workforce at high risk of infection and heightened the risk and the number of deaths in the care homes.”³²

68. Further, the GMB stated that although the Welsh Government took action to distribute to social care settings on 21 March and from central stocks to Health Boards on 25 March, many providers still struggled to maintain supplies for a number of weeks after this date.

³⁰ Written evidence, C36

³¹ [Supporting social care during the coronavirus outbreak](#) – 29 April 2020

³² Written evidence, C46

69. Care Forum Wales also highlighted issues around the predictability of the supply:

“I had one provider speak to me yesterday to say, ‘Oh, it’s brilliant, we’ve received (...) 6,000 gloves, whereas last time, in the last few weeks, we got a box of a 100. And so, it’s great, but we didn’t know if we were going to get that and we don’t know what we’re going to get through that route next week.”³³

70. Accessibility of supply had also caused problems for the sector:

“a lot of PPE suppliers were only dealing with existing clients. If you happened to be an existing client of a firm that had things in stock that Public Health England were saying could only be sold to providers in England, then you weren’t able to access those, but you also weren’t able to access them from alternative suppliers in the way you normally would, because they were only dealing with existing clients.”³⁴

71. Finally, we were told that the increasing cost of PPE is a significant concern for the sector going forward:

“the problem with PPE is a lot of it is not reusable, and so we’ve got continuing concerns going forward about if something were to happen to break supply chains again, or simply just the escalating costs. We’ve been in contact with suppliers who are talking about 200 per cent increases in the costs of PPE going forward, and, obviously, that’s another financial burden for providers”³⁵

72. The WLGA praised the sector for the way in which it had responded to the challenges posed by COVID-19, saying:

“the workforce is doing an incredible job in extremely testing circumstances, many going above and beyond to care for people. However, it is also a dangerous job with the risk posed by the virus, with colleagues putting themselves, their families and their communities at risk.”³⁶

³³ RoP, 7 May 2020, paragraph 262

³⁴ RoP, 7 May 2020, paragraph 272

³⁵ RoP, 7 May 2020, paragraph 244

³⁶ Written evidence, C2

73. It said that, at the outset of the outbreak, local government had escalated significant concerns about the limited availability of PPE from Welsh Government stocks for social care staff, including lack of clarity on stock levels and inconsistent and incomplete supplies being made available across authorities. Concerns about the supply of PPE dominated early discussions between leaders and Ministers and remained a significant risk for many authorities. Councillor Huw David told us:

“Initially, all Members will be aware that there were significant concerns about the limited availability of PPE. That has been addressed. We saw the new guidance back at the start of April, which led to a big increase in the demand and use of PPE. We’ve now got a stable supply from Welsh Government, and we are able to meet the current needs. We are, of course, very cautious, because if restrictions continue to be lifted and there’s a demand for PPE in other sectors of society, then that may have an impact on the overall total supply, and I know that, with Welsh Government, we are looking at opportunities to secure future supplies from here in Wales.”³⁷

74. The situation was further exacerbated by the need to provide support to the independent care home sector, who would previously have sourced their own PPE supplies, but found they were struggling because supplies were being bought up centrally for use in the health service. On 30 April, the Minister told us:

“... it became very clear that the Government, through the National Health Service, would need to provide PPE to the social care sector, because their supply lines had collapsed, they weren’t able to provide PPE. And whilst it’s legally the employer’s responsibility to provide PPE to their workers, if we’d said, ‘We’re not helping social care’, then we could all predict in a few easy steps what would have happened to businesses in that sector and to workers in that sector who’d have been left unprotected. So, we stepped in, and that is the measure of the extraordinary times that we’re in to provide free, state-provided personal protective equipment to a largely independent sector business.”³⁸

75. The WLGA said that a significant amount of work and discussions had and continued to take place on increasing and improving PPE supply and current

³⁷ RoP, 21 May 2020, paragraph 94

³⁸ RoP, 30 April 2020, paragraph 234

indications were that supplies to councils from the NHS Shared Services Partnership were now improving.

76. Councillor Andrew Morgan confirmed that, as far as he was aware, no local authority had run out of PPE but, “what we did come down to is, literally, within perhaps hours of PPE being available, where we had to get emergency deliveries to us and then out to the private and independent care sector as well”.³⁹ He went on to say:

“There is a robust system in place. (...) I’ve had no complaints on PPE for the last couple of weeks. Initially, I think it was around understanding exactly who needed it and making sure we had those. Ideally, every council leader would like to say to their staff, ‘We’ve got a store of a week’s or two weeks’ worth of PPE’. Unfortunately, at best we had a day’s supply of PPE, and that’s why it was critical to make sure we kept getting those supplies.”⁴⁰

77. Finally, it advised that the Welsh Government had commissioned Deloitte to provide demand mapping to help organise supplies of PPE more efficiently going forward and the WLGA had been helping to coordinate the demand data for local authorities:

“There remains a need to be cautious about how supplies are distributed as quantities are huge and supply arrangements are still being developed however, good working relationships have been established with the NHS Shared Services Partnership and across procurement teams in Wales.”⁴¹

Domiciliary care

78. The lack of PPE for domiciliary care workers was also raised in evidence to us. We heard of the frustrations of one carer regarding the lack of PPE for the paid carers who were coming in to support his wife, “putting their own life and the lives of him and his wife who is living with dementia in danger”. The carer was aware it was not the fault of the care worker but felt that social services or the care provider should have dealt with this.⁴²

³⁹ RoP, 21 May 2020, paragraph 96

⁴⁰ RoP, 21 May 2020, paragraph 100

⁴¹ Written evidence, C26

⁴² Written evidence, C28

79. The MS Society⁴³, Motor Neurone Disease Association⁴⁴ and Tide (together in dementia everyday)⁴⁵ told us that the lack of PPE was causing some people to cancel their care in order to protect themselves from infection. This was putting an added strain on them at a time when their mental health was suffering as a result of self-isolation and lack of respite provision.

80. More broadly, the Royal College of Emergency Medicine raised concerns that a lack of provision of PPE in social care could have adverse consequences for Emergency Departments, as a rising infection rate in care homes would mean more patients requiring admission to the Emergency Department. It also told us that clinicians in Emergency Departments were starting to see an increase in attendances from minors and ‘well COVID-19’ patients who, until recently, had avoided attending Emergency Departments, which would also result in the use of more PPE.⁴⁶

Hospices

81. Evidence from Hospices UK and Hospice Cymru noted that hospices in Wales have been included in supplies of PPE from their local health boards and that, following some issues in late March, “most hospices are now part of their health board’s weekly supply planning process”. This, they stated, was in contrast to hospices in England that were only included in NHS England PPE supply chains from early May. Despite this, it stated:

“most hospices are still reliant on purchasing PPE through private suppliers (where supply is available) and on the generous donations of PPE from their communities.”⁴⁷

82. It called for “a more uniform and established approach that results in all hospices receiving what they need”.

83. Further, it stated that, as steps to recovery are taken by the Welsh Government, it hoped that “measures will be included that provide greater security and confidence to end of life care providers”. Guarantees that they will be able to receive the required volume of PPE in a timely fashion will enable hospices

⁴³ Written evidence, C24

⁴⁴ Written evidence, C40

⁴⁵ Written evidence, C28

⁴⁶ Written evidence, C37

⁴⁷ Written evidence, C20

to plan further ahead and increase their capacity to support the recovery framework.⁴⁸

Our view

84. The lack of appropriate personal protective equipment (PPE) was one of the biggest issues during the early part of the outbreak.

85. PPE is essential in ensuring a safe environment for the care of people with coronavirus and avoiding infection for those giving and receiving care. It is extremely concerning, therefore, that we have, on occasions, come within days of running out. Indeed, the Minister himself told us that the availability of PPE was his biggest anxiety for some time.

86. Also concerning were the reports of the anxiety and fear experienced by many frontline staff without access to appropriate PPE. We heard that some had been required to re-use single-use PPE, or even source their own masks and scrubs as they were not able to obtain them through official stocks.

87. A failure to communicate effectively in the early part of the outbreak led to confusion about what PPE was appropriate to use in different circumstances. Further, there was a perception amongst some staff that advice on appropriate use of PPE, agreed on a UK-wide basis, changed according to what was available rather than what was needed. This damaged confidence and morale. The Welsh Government and its partners need to learn from this, and ensure that similar circumstances do not arise again.

88. There were also serious problems with the distribution of PPE, with many, including local government, pharmacists and social care providers, reporting issues with supplies reaching them.

89. The position has improved over time in terms of supply, availability and distribution of PPE as a result of concerted efforts by NHS Wales, local government and the Welsh Government, either individually or in collaboration with UK counterparts. Further, we welcome the mutual aid arrangements that have developed with the other UK nations that have been critical on occasions when one or other has experienced shortages in supplies.

⁴⁸ Hospice UK and Hospice Cymru, written evidence

90. However, in the words of the Welsh Government, the system remains ‘stable but it is fragile’.

91. The approach within the UK of relying on overseas providers for PPE and securing supplies ‘just in time’ for when they are needed has been found wanting in the face of a global pandemic and the pressures that arose from that. The Welsh Government and its partners must take urgent steps to remedy these problems in advance of any further outbreak.

92. In doing so, the issues raised in this report around the design and fit of PPE must be addressed, along with the need to ensure that PPE is suitable for staff, patients or carers who are deaf or hearing impaired.

Recommendation 1. The Welsh Government must, as a matter of urgency:

- publish a strategy for securing a resilient supply of PPE;
- stockpile appropriate PPE in sufficient quantities for any future outbreak;
- keep under review the PPE it has stockpiled to ensure that it remains of adequate quality and is fit for purpose, including that the design and fit is appropriate for all wearers and suitable for staff, patients or carers who are deaf or hearing impaired;
- publish a strategy for ensuring resilience of distribution arrangements for PPE;
- work with partners to ensure that guidance on PPE is kept up to date in the light of the most recent scientific advice, and communicate this advice clearly to staff.

93. We recognise the work being done by the Welsh Government to develop resilience in supply by encouraging domestic production of PPE. Many Welsh businesses have diversified out of their usual areas of production to assist the emergency response. At some point, they may wish to return to their core business, unless the PPE products they have been making continue to be a viable line for them. We believe there is merit in the Welsh Government considering the options for supporting local businesses that wish to continue making PPE, either as a main product or an expansion of their existing business.

94. Linked to this, we are aware of many offers made by a number of Welsh businesses to the Welsh Government to provide PPE that were never followed up. This problem needs to be addressed before any further outbreak so that systems

are in place for evaluating and making best use of offers of help in a timely manner.

Recommendation 2. The Welsh Government must review its own systems to ensure the mechanisms are in place to enable manufacturers in Wales to respond quickly in supplying appropriate PPE in the event of any future outbreaks. This must include having procurement arrangements that are able to respond in a timely manner.

95. Securing adequate supplies of PPE was a considerable challenge for the social care sector, particularly in the early days of the outbreak. We heard that major supplies coming into the UK were being directed to the NHS, leaving the sector largely to fend for itself. Some supplies were provided by the Welsh Government and local authorities, and these helped to supplement those which providers were buying themselves.

96. It is essential that, as we move forward, and particularly as we move out of lockdown and visiting restrictions are relaxed, adequate supplies of PPE are maintained for use in the social care sector.

97. Further to this, we are aware of some problems experienced by third sector organisations in accessing appropriate PPE. These organisations provide vital care services to some of our most vulnerable people. We believe that anyone providing such services should have access to the PPE they need.

Recommendation 3. The Welsh Government must ensure that third sector organisations providing vital care services have reliable access to appropriate PPE.

98. Finally, the Members of the Health and Social Care Committee have been overwhelmed by the amazing contribution of the many volunteers across the country in producing PPE. We wish to take this opportunity to pay tribute to all those who have been making masks, sewing scrubs and gowns and printing visors. Your contribution is greatly appreciated and really shows our communities at their very best.

4. Testing

Guidance on testing

99. Guidance on testing has changed in light of emerging scientific evidence and increasing capacity.

100. In March, following the move from the containment phase to the delay phase, testing in Wales was initially prioritised for individuals requiring admission to hospital, followed by a phased rollout of testing for health care workers involved in frontline patient facing clinical care as capacity increased⁴⁹.

101. Updated guidance on testing was published by the Welsh Government on 30 May⁵⁰. This expanded testing to members of the public who were experiencing symptoms, and included adults and children. The test needs to be taken in the first five days of having symptoms and individuals are able to choose between a drive-through testing centre or ordering a home testing kit.

Accessibility

102. We received initial reports of health professionals having difficulty in accessing testing. A survey of its members carried out by RCN Wales found that:

“Of the 556 respondents who said they needed a test 255 were offered it or 45.9%.”

103. It further stated that although the Welsh Government had published clear testing guidance and policy, “it is important this guidance is understood and accessible to frontline workers and management across Wales. Only 50 per cent of respondents knew how to access/apply for testing in their place of work.”⁵¹

104. By mid-May, however, they were reporting some improvement albeit “quite small”:

⁴⁹ [Written Statement: Coronavirus \(Covid-19\) – Testing](#) – 18 March 2020

⁵⁰ [Apply for a Coronavirus Test](#) – 30 May 2020

⁵¹ Written evidence, C05

“the data shows that we’ve still got some work to do, although that is improving, to make sure that we get the message out about who can have the test and who can’t.”⁵²

105. The Royal College of GPs also felt the testing process had improved in terms of access, although reported there was still some variation across Wales:

“if you look back to March, I know that some of my colleagues have e-mailed and tweeted members on the committee already about difficulties they had, and particularly if they’re working freelance. But those difficulties seem to have been erased now and people seem to be able to access tests very well. I think that’s because the system’s become a little bit more refined.”⁵³

106. Evidence from the Welsh Ambulance Services NHS Trust also highlighted variability across Wales, although suggested that this had now settled and become more streamlined. It also talked of “a level of employee and organisational frustration with referral processes, speed of access and processes for receiving results” and concluded that:

“The majority of these issues have now been resolved but, as the country moves to a “test, trace, protect” model, smooth, rapid and uniform processes will be important.”⁵⁴

107. According to BMA Cymru Wales:

“it is apparent from the data and member feedback, that the increased capacity within the testing system is not being used to its fullest extent and there are still clear operational challenges in accessing tests from within health boards and in primary care.”⁵⁵

108. It went on to say that as plans are discussed for the resumption of areas of the health service that have been suspended, it is vital that a system of regular and repeated testing is available to healthcare staff to allow them to both return to work after self-isolation, and to provide ongoing assurance to staff and patients.

⁵² RoP, 14 May 2020, paragraph 72

⁵³ RoP, 14 May 2020, paragraph 77

⁵⁴ Written evidence, C41

⁵⁵ Written evidence, C27

It further suggested that going forward, “asymptomatic staff should be regularly tested as the service opens up to provide regular assurance on viral transmission”.

109. Similarly, the Royal College of Surgeons called for “hospitals to be aware of their diagnostic testing availability and develop clear policies for addressing testing requirements and frequency for staff and patients”. It also suggested that testing capacity in Wales should be dramatically increased and, as in England, should be extended to include asymptomatic staff.⁵⁶

110. Witnesses, including the Royal College of Physicians and Royal College of Psychiatrists, highlighted the need for access to testing for household members of NHS staff. The Royal College of Physicians told us:

“31% [of members surveyed] said they were still unable to access testing for a symptomatic member of their household. Knowing whether household members have coronavirus could be the difference between an NHS frontline worker returning to work or potentially self-isolating for 14 days without confirmation of diagnosis.”⁵⁷

111. It should be noted that, since 18 May, all people over the age of 5 with symptoms are now eligible for testing.

112. We also heard of the need to improve turnaround times for results, with a number of respondents highlighting regional variations. According to the RCN Wales:

“There are regional differences in the time it takes to return a test result; only 36% of respondents in North Wales received their tests in 2 days, compared to 59% in South Wales Central.”⁵⁸

113. This view was echoed by the Royal College of Emergency Medicine who acknowledged the efforts being made to get more rapid testing but concluded:

“there remains an unacceptable variation in terms of receiving tests and the turnaround with regard to results. A rapid result makes it possible to move a patient to a COVID-positive or negative ward quickly and reduces the potential for admitting patients to COVID-19 wards with suspected COVID-19 who subsequently test negative. Keeping

⁵⁶ Written evidence, C22

⁵⁷ Written evidence, C08

⁵⁸ Written evidence, C05

community wards safe is paramount but keeping patients in hospital for up to 14 days will put considerable pressure on secondary care.”⁵⁹

Capacity

114. In a written statement dated 21 March 2020, the Minister for Health and Social Services advised that, “testing capacity has continued to be ramped up and Public Health Wales now has capacity for over 800 tests per day”.

“From 1 April, this will increase by a further 5,000 tests per day (total – 6,000 daily).

From 7 April, this will increase by a further 2,000 tests per day (total – 8,000 daily).

By end of April, Public Health Wales are aiming to have capacity to undertake up to 9,000 tests per day in Wales.”⁶⁰

115. However, the review of testing for Covid-19 published on 18 April described a “range of delays” and “supply chain issues”, and confirmed that the target of 5,000 tests by the third week of April would not be reached.⁶¹ The review recommended improving processes for test referral and results, and committed to weekly updates setting out expected and actual increases in testing capacity.

116. On 20 April, the First Minister confirmed that the target for 5,000 daily tests was being abandoned, and in Plenary on 22 April, the Minister for Health and Social Services set out that:

“The reason, though, why we’re not having to test 5,000 people a day and more is because of the social distancing that’s been introduced, because of the measures we took to put the country into lockdown...”⁶²

117. This was supported by Dr Rob Orford, who told us:

“I made the forecast back in early March and [] we’re at the end of April now. If you reflect backwards, the reasonable worst-case scenarios that we’d forecast for unmitigated access of this virus into the community was significant. The control measures that we’ve put in place have

⁵⁹ Written evidence, C37

⁶⁰ [Written Statement: Coronavirus \(Covid-19\) – Update](#) – 21 March 2020

⁶¹ [Review of testing for COVID-19](#) – 18 April 2020

⁶² RoP, Plenary, 22 April 2020, paragraph 125

suppressed the epidemic significantly in Wales []. And so, some of the forecasts were based on potential numbers that we might be seeing coming through the door at hospitals each day, and that's been a success story that perhaps we haven't considered. The might of the public in observing those social distancing measures has suppressed the epidemic so significantly that we're not getting the anticipated flow."⁶³

118. In evidence to this Committee on 4 June, the Minister told us:

"the rapid review that was undertaken in mid-April made very clear that we weren't going to reach the 5,000-odd tests that we had expected to and it set out the reasons why, and they were honest and truthful reasons. The fact that we've now significantly increased our capacity is because those imports have taken place, and so the figures that you see on the testing updates that we provide are the actual lab testing capacity. So, we do have more than 9,500 testing capacity available to us now. We expect to get more, and each week I'll continue to provide an update on what we're actually doing", and I think that matters. I think that matters to give people confidence."⁶⁴

119. When asked about the impact of the delays in building up capacity for testing, Prof Deenan Pillay, Independent SAGE, told us:

"a focus on numbers of tests is a sort of irrelevancy, is a political target. What matters is what are the protocols and procedures for who we find to test, surely. If we say on the one hand we're only going to be testing those individuals who are sick enough to come into hospital (...), then we're only going to test people who are sick enough to come into hospital; we're not going to be testing people in the community. So, that is what determines the number of tests that are done, rather than just a target of tests, which always seemed a disconnect."⁶⁵

120. The weekly testing figures for 21 June show that 154,206 tests had been carried out in Wales (representing 122,845 individual tests), including 26,840 healthcare workers, 35,412 care home workers, and 26,441 care home residents⁶⁶.

⁶³ RoP, 30 April 2020, paragraph 75

⁶⁴ RoP, 4 June 2020, paragraph 63

⁶⁵ RoP, 18 June 2020, paragraph 110

⁶⁶ [Testing weekly update 23 June 2020](#): Coronavirus

The laboratory capacity at 21 June was 12,562 daily tests. The most recent Public Health Wales figures report that 3,054 tests were undertaken on 5 July⁶⁷.

Testing in care homes

121. Testing in care homes has proved to be a controversial issue, with both the UK and Welsh Government coming under criticism for the lack of testing in care settings, and particularly for not testing hospital patients on discharge to care homes sooner.

122. ONS figures show there have been 663 Covid-19 deaths in Welsh care homes to 12 June - accounting for 28 per cent of all coronavirus deaths in Wales.

123. According to Care Forum Wales “accepting hospital patients into care homes has played a major role in enabling the spread of the infection in care homes at such an alarming rate”.⁶⁸

124. Mario Kreft told us:

“... the barriers seem to us to be that we started from this position on testing where there was not going to be any. We were told, quite categorically, unless they’re showing symptoms, they’re not going to be tested. So, people were being discharged from hospital to very-well-meaning people in the care sector in Wales, often with smaller homes, with people who had not been tested because they were not showing symptoms.”⁶⁹

125. Speaking in the Welsh Government daily briefing on 23 June⁷⁰, the Minister for Health and Social Services said that there was currently no evidence that the discharge of patients into care homes without a coronavirus test had led to more deaths. He said that the decision taken was based on the evidence and advice at that time.

126. The WLGA called for people to be tested twice before being discharged into care homes. Councillor Andrew Morgan told us:

⁶⁷ [Public Health Wales Rapid Covid-19 Surveillance](#)

⁶⁸ [Care Industry News](#), 29 April 2020

⁶⁹ RoP, 7 May 2020, paragraph 224

⁷⁰ [Welsh Government Daily Briefing](#), 23 June 2020

“if there’s an opportunity for people to be tested twice before they’re discharged, because [] on occasion, there is a false-negative on the test, (...) I think all council leaders would welcome that.”⁷¹

127. The Older People’s Commissioner for Wales has called for the Welsh Government to be investigated by the Equality and Human Rights Commission (EHRC) over concerns that older people’s rights may have been breached in care homes. The Commissioner has concerns that older people’s rights may not have been sufficiently protected in these settings and across health and social care more widely:

“The situation we have seen in our care homes during the Covid-19 pandemic has been a tragedy, and I have concerns that older people’s rights may not have been sufficiently protected, in these settings and across health and social care more widely.”⁷²

128. Ruth Coombs, EHRC Head of Wales, has responded to say “we remain deeply concerned about serious potential breaches of older people’s human rights during this pandemic”. EHRC Wales said it is working closely with the Commissioner and “is considering the use of all our powers to protect older people’s rights”.

129. WLGA and ADSS Cymru highlighted the importance of testing for social care staff. In a joint statement issued on 20 March, they said “it is vital that our frontline staff do receive testing, in the same way that healthcare staff are being tested, to enable them to carry on providing services”.⁷³

130. Care Forum Wales told us that it believed “regular and prompt testing, and speedy revelation of the results” were key to improving the situation in Welsh care homes.⁷⁴ WLGA also raised the importance of receiving results in a timely manner, saying:

“that’s where we’ve had some difficulty, is actually in the delay in getting the results back. It’s vastly improved, but at some points, we’ve been waiting as long as four days for test results.”⁷⁵

⁷¹ RoP, 21 May 2020, paragraph 58

⁷² Older People’s Commissioner for Wales – 21 May 2020

⁷³ Coronavirus: Joint Statement by ADSS Cymru and WLGA - Friday, 20 March 2020

⁷⁴ RoP, 7 May 2020, paragraph 267

⁷⁵ RoP, 21 May 2020, paragraph 60

131. Welsh Government policy in relation to testing in care homes has changed rapidly and often. An updated policy, which extended testing to all critical workers (including care staff) if they or their family has symptoms, was published on 18 April⁷⁶. On 22 April 2020, the Minister for Health and Social Services told Plenary “we’re now testing all symptomatic care home residents and all care home residents who are returning from hospital. All symptomatic care home workers themselves can now also be referred for testing”.⁷⁷

132. On 2 May testing was extended to all residents and staff in care homes with outbreaks or homes with 50 beds⁷⁸.

133. However, in evidence to the Committee, Care Forum Wales suggested that the threshold of 50 beds was somewhat arbitrary:

“I have absolutely no idea where the 50 came from, because the average care home in Wales is not 50 beds. You couldn’t build a 50-bed home today and make it viable. You’d have to be at least north of 60 and probably in the 70s. But the truth is that, in Wales, most care homes are [] 30 or 40-beds.”⁷⁹

134. This was shortly followed by the announcement on 16 May that “every care home in Wales can access testing for residents and staff”.⁸⁰ However, this was considerably later than both England (28 April) and Scotland (1 May).

135. In evidence to this Committee on 4 June, the Minister said:

“so we’re now testing everyone in the care home environment because we have changed our policy. Over the course of six weeks, we made three different policy decisions. And it again highlights the rapid evolution and our understanding of not just the way that coronavirus behaves, but evidence around it as well. And at each of those points where I made a different decision, it was because the evidence base and the advice had changed.”⁸¹

136. On 9 June, the Minister further announced that:

⁷⁶ [Key \(critical\) workers testing policy: Coronavirus \(Covid-19\)](#) – 18 April 2020

⁷⁷ RoP, Plenary, 22 April 2020, paragraph 93

⁷⁸ [Welsh Government extends coronavirus testing in care homes](#) – 2 May 2020

⁷⁹ RoP, 7 May 2020, paragraph 237

⁸⁰ [Welsh Government extends testing to all care homes](#) – 16 May 2020

⁸¹ RoP, 4 June 2020, paragraph 76

“From Monday 15th June, all care home staff will be offered a weekly test for a four-week period. These will be self-administered swabs acquired either through the Care Home Portal or directly from the health board. We are keeping it under review, following this point we will assess the impact and consider next steps to ensure that we can continue to safeguard our care homes.”⁸²

Our view

137. There has been a complete lack of clarity about the testing programme in Wales; with uncertainty about who was leading, managing and coordinating the work. This has been a cause for confusion and concern.

138. We heard reports that, in the early stages of the outbreak, many health professionals had difficulty in accessing testing, while others expressed frustration at the time taken to obtain a test and receive their results.

139. Some of these early issues around accessibility seem to have been resolved, but the importance of having a streamlined and clear process for testing in place cannot be understated, particularly as we move to the ‘Test, Trace, Protect’ model.

140. One of the main lessons from the last few months is that access to testing, as and when it is needed, is paramount. We believe there is an important role here for GPs and primary care.

141. Linked to this, communication about the importance of testing, and how to access it, will be vital. There is an on-going need for clear and responsive public messaging about when to get tested, and how to go about this. This also needs to be able to respond to specific needs or circumstances, such as significant local outbreaks or spikes.

142. This messaging should also emphasise that testing is a valuable tool in helping to understand how the virus works and developing solutions to address it. This will be particularly important if public buy-in to the Test, Trace, Protect strategy is to be achieved and testing capacity is used fully and to best effect.

Recommendation 4. The Welsh Government, and its partners, must ensure that there is local access to testing for anyone who needs it, as and when they need it. GPs and primary care need to be an integral part of these arrangements.

⁸² [Written statement: Care home testing update](#) – 9 June 2020

Recommendation 5. The Welsh Government, working with its partners, must ensure an ongoing campaign of clear, consistent and repeated public messaging – at a national and local level – about when to seek a test for Covid-19 and how to do this.

Recommendation 6. The Welsh Government should ensure there is similarly clear and consistent messaging about the value of testing, not only in identifying people with the virus but to assist in research and development of future solutions.

143. Looking ahead, it will be particularly important to the resumption of routine NHS services that a system of regular and repeated testing is in place for health care workers, including asymptomatic staff. This will give confidence to both staff and patients about being able to access NHS services safely. There should be similar arrangements in the care sector. There will be a need to ensure that sufficient capacity is available to support this.

Recommendation 7. The Welsh Government, working with NHS Wales, must develop a clear plan for regular and repeated testing of health and social care staff, including asymptomatic staff.

Capacity

144. It is important to recognise that making testing capacity available is, in itself, only part of delivering an effective testing regime. It must be accompanied by plans that ensure that capacity is accessible and well-publicised, as well as used appropriately and as fully as possible. Looking ahead, it is important to have a clear picture of likely future demand, particularly going into the winter months. We need to be confident that supply will meet increased demand.

Recommendation 8. Given the concerns about a future second spike of infection, the Welsh Government, working with its partners, should assess the likely future demand for testing and take steps to ensure there is sufficient capacity so that anyone who needs a test will be able to access one quickly and easily. As part of this, the Welsh Government and partners must remain alive to the development of different types of testing models.

Turnaround times for test results

145. Delivery of the Test, Trace, Protect Strategy will require a focused and sustained effort on reducing waiting times for test results. This is particularly important in ensuring people are not self-isolating for longer than necessary. Many witnesses told us of unacceptable variations in turnaround time for test results,

with north Wales being considerably slower than the south east. This must be addressed to ensure that no area or region in Wales is disadvantaged by having to wait longer than others.

146. Our detailed views and recommendations on this subject are set out in Chapter 6 on the Test, Trace, Protect Strategy.

Care homes

147. We are deeply troubled by the number of Covid-related deaths in care homes. Care homes look after some of our oldest and most vulnerable members of society. They deserve to be protected in the event of a national health emergency, yet they have been badly let down during this crisis.

148. It is our view that the Welsh Government's initial approach to testing in care homes was flawed, and that it was subsequently too slow in responding to the mounting crisis that has seen deaths in care homes account for 28 per cent of all coronavirus deaths in Wales. We note the very public criticism of the Welsh Government's actions by the Older People's Commissioner for Wales, and her referral of the government to the Equality and Human Rights Commission.

149. It took too long to implement appropriate testing measures for care homes. The initial decision not to test hospital patients being discharged into care homes has subsequently been reversed, as has the decision not to test residents and staff in care homes unless they are showing symptoms; the latter was done considerably later than in England and Scotland. Both decisions have come at great cost to the social care sector.

Recommendation 9. The Welsh Government must ensure that all patients being discharged from hospital directly into a care home have been tested in accordance with latest best practice to ensure maximum protection for residents and staff.

Testing for care home staff

150. The need for regular testing for care home staff is clear. We welcome the principle that all care home staff will be offered a weekly test for a four-week period, but again believe this has come too late.

151. Further, we are concerned about the use of home testing kits for care home staff. The accuracy of tests is currently only around 70 per cent when administered by a trained professional. We believe there is scope for this to be much lower in home testing, due to the invasive way in which the sample needs

to be collected. Our view on home testing kits, and the relevant recommendation, is set out in Chapter 6 on the Test, Trace, Protect Strategy (paragraphs 283-4, and Recommendation 21).

152. Moving forward, there is a need to be confident about the ongoing availability of tests for care home residents and staff, particularly as visitor restrictions are relaxed. We believe that care homes should be entitled to the same access to testing as hospitals, including the methods of testing.

Recommendation 10. The Welsh Government must ensure that:

- testing within care homes takes place on a regular and systematic basis,
- such tests are administered by suitably trained individuals rather than using home testing kits and
- sufficient capacity is available to support both of the above.

5. Shielding of Extremely Vulnerable People

153. Since the middle of March 2020, those who were deemed to be extremely vulnerable to coronavirus have been told to ‘shield’.

154. Shielding means protecting those people who are extremely vulnerable to coronavirus due to certain existing health conditions. A list of these health conditions is included in the [Welsh Government’s shielding guidance](#).

155. As of 17 June 2020, a total of 127,095 people are on the shielded patient list in Wales.

Shielding letters

156. People identified as extremely vulnerable should have received a letter from the Chief Medical Officer for Wales, known as a ‘shielding letter’. This contained information and advice, including accessing medication and other essential items.

157. For any person who believes they fall into one of the categories of extremely vulnerable people and have not received a letter, the Welsh Government advises them to discuss concerns with their GP or hospital doctor. The guidance says that “to ensure all high risk patients are contacted, GPs and hospital doctors are able to add people to the shielding list”.

158. Prior to 1 June 2020, people who are shielding were advised to stay at home at all times and avoid any face-to-face contact. From 1 June, this advice changed and those shielding are now able to leave home to exercise or meet outside with people from another household, whilst observing social distancing and practicing good hygiene. The most recent guidance advises those shielding that they should continue to do so until the 16 August 2020.

159. On 15 April, the Minister for Health and Social Services apologised after it was discovered that a “processing error within the NHS Wales Informatics Service” had resulted in around 13,000 shielding letters being posted to a previous address in cases where the intended recipient had recently moved house. He confirmed that all letters had been re-sent and should be received in the next few days.

160. A number of those who have provided evidence to us have identified issues arising from the guidance. One such issue highlighted by the Royal College of General Practitioners (RCGP) was the delay in shielding letters being issued. This, it stated, led to confusion for patients and GPs with information appearing in the media and on official websites before the letters were received.

161. Further, the RCGP was concerned about the “miscommunication” around Advanced Care Planning (ACP), which “led to some distress” following news coverage of a controversial incident.⁸³ The RCGP stated:

“In retrospect a better approach would have been for a clear message from Welsh Government that there was a need for ACP conversations and that these would be about best understanding the most comfortable environment for a patient while ensuring they were receiving all appropriate care. That would have then framed the conversation allowing GPs to have productive conversations with patients.”⁸⁴

162. Related to this was the conflation of ACP with the Do Not Resuscitate (DNR) instruction. On this point, the RCGP stated that ACP is good medical practice when done sensitively. ACP and DNR - although both requiring extremely sensitive discussions - are separate issues.⁸⁵

163. Evidence from some third sector organisations highlighted the confusion facing many of those they represent about the guidance on shielding and the support available. Parkinson’s Cymru described “confusion and anxiety from the Parkinson’s community about the vulnerable and extremely vulnerable categories and the support that’s being offered to these individuals”. They encourage the Welsh Government and NHS Wales to be clear about support that is being provided to those being shielded.⁸⁶

164. Similarly, the All Wales Forum of Parents and Carers of People with Learning Disabilities said they felt there had been a “lack of specific instructions (...) to people with Learning Disability. Especially to be able to clarify what to do if you did not receive a shielding letter, or if your GP has described you as ‘vulnerable’”.⁸⁷

165. Both the Motor Neurone Disease Association and the Asthma UK and British Lung Foundation Partnership referenced concerns about conditions that do not appear on the shielding list. The Motor Neurone Disease Association noted that the Welsh Government has “elected not to add all people with MND to the extremely vulnerable list, despite MND being a terminal and rapidly progressive

⁸³ Written evidence, C03

⁸⁴ Written evidence, C03

⁸⁵ Written evidence, C03

⁸⁶ Written evidence, C30

⁸⁷ Written evidence, C43

condition which causes significant respiratory and bulbar impairment. As a result, people with MND must be registered individually by their clinician”.

166. The Association is concerned that GPs will remove people with MND from the shielding list in error, and it calls on the Welsh Government to ensure that GPs contact a person’s specialist care team to understand their current degree of MND progression before making any decision to remove shielding status.⁸⁸

167. In its evidence, the Asthma UK and British Lung Foundation Partnership stated that, although large numbers of people with respiratory conditions had been advised to shield, its own survey found that, in Wales, just under 10 per cent of respondents had received a letter or text advising them to shield. This was, it noted, by far the lowest percentage of respondents by region, the average from the other UK nations being 17.7 per cent.

168. It suggested that this low figure in Wales “might be reflective of the 13,000 letters (16 per cent of the overall figure) sent to the wrong address”, or as a result of certain lung conditions not having been included on the original distribution list.⁸⁹

Role of local government

169. Evidence from the WLGA described the “significant role” played by local authorities in providing support to people advised to shield. It stated:

“All local authorities have considered how best to support shielded people, and the majority have been proactive in contacting each person on the list to highlight the support available (...) and to ensure they know to contact the council if they need help and do not have family and friends to call upon. Local authorities are also processing orders for free food boxes from Welsh Government for those unable to rely on a food source elsewhere.”⁹⁰

170. We heard that local authorities were given “only given three days’ notice” that the shielding exercise was to be announced and that, at that time, it was estimated that there could be around 100,000 people who would be shielded and would need support services”.⁹¹

⁸⁸ Written evidence, C40

⁸⁹ Written evidence, C16

⁹⁰ Written evidence, C26

⁹¹ RoP, 21 May 2020, paragraph 134

171. Despite that, the WLGA said that local authorities were “quick to put in place arrangements to identify and respond to a range of support needs local communities have required” and that, through working in partnership with others,

“local arrangements have been put in place that reflect local circumstances, making best use of local resources and capacity and by knowing and understanding the specific needs of their local communities and in particular those who are vulnerable or in particular need of support.”⁹²

172. It acknowledged that there had been some confusion as a result of the development of a national scheme for shielded people, with free food boxes, but limited eligibility to those shielding:

“The earlier announcement of a scheme in England (and the lack of clarity in the press on it only being available in England and the ensuing confusion) added to the complexity of developing a scheme in Wales at pace.

The pace in establishing the national scheme meant several teething problems around communication, coordination and the way in which the data lists have been shared (...) and the many problems or changes encountered in developing the scheme (GP additions, wrongly addressed letters) has added to the challenge for local authorities to make sense and operationalise the scheme.”⁹³

173. The WLGA felt that an “opportunity to review the scheme and amend its operation as appropriate, including suggestions for improvements moving forward would be welcomed, particularly if it is to continue after the initial 12 weeks”. It felt that there may be other ways to develop a “more efficient and effective system to ensure the support needs of shielded people, and those of other vulnerable or at risk groups, can be met over a sustainable period of time”.⁹⁴

174. In relation to volunteering, the WLGA stated that the response to calls for volunteers had been “fantastic”.⁹⁵ However, it referred to uncertainty as a result of different approaches taken across the UK, particularly in relation to volunteering. It noted that the UK-wide publicity for an England-only scheme led to confusion in

⁹² Written evidence, C26

⁹³ Written evidence, C26

⁹⁴ Written evidence, C26

⁹⁵ RoP, 21 May 2020, paragraph 138

Wales about how to volunteer. This meant that further work was then needed to work out the best way of co-ordinating volunteers between local government and third sector groups. It noted that the approach in Wales had built on existing partnerships between local authorities, the third sector and community and town councils.⁹⁶

175. It stated that it meets regularly with the WCVA and Welsh Government to discuss arrangements and the longer-term need for, role and availability of volunteers as lockdown eases, giving consideration to how the support needs of some vulnerable people can continue to be met.⁹⁷

Services for people advised to shield

176. The shielding letter from the Chief Medical Officer for Wales contained information and advice on a range of matters, including support for getting medication and other essential items such as food.

177. The letter states that local authorities have been provided with the contact details of those who have been identified as high risk to allow them to offer support, and major supermarkets have been provided with the contact details of those who have been identified as high risk to allow them to prioritise online shopping slots.⁹⁸

178. The Welsh Government has taken a different approach to England in providing support to those shielding. People in Wales have not been asked to register as vulnerable, as people in England are able to. Instead the Welsh Government is advising that vulnerable people ask family, friends and neighbours for help first, or use online services, and then ask local voluntary organisations, before contacting their local authority for help.

179. In evidence to this Committee, the RCGP was critical of the decision to link shielding with the provision of key services, such as supermarket deliveries and prescription collection. They said that this led to an increased workload for GPs and put pressure on them to provide shielding letters to patients, "it would have been better to try and separate the access to services from the medical advice".⁹⁹

⁹⁶ Written evidence, C26

⁹⁷ Written evidence, C26

⁹⁸ [CMO letter to extremely vulnerable people: support explained](#)

⁹⁹ RoP, 14 May 2020, paragraph 86

180. This issue has also been raised by care homes struggling to access food deliveries, and by the Asthma UK and British Lung Foundation Partnership, who stated that 87 per cent of respondents to its survey who described having trouble getting groceries had not received a shielding letter. It said that this was a cause for concern as restrictions begin to be lifted and people are asked to return to work.¹⁰⁰

181. In addition, the All Wales Forum of Parents and Carers of People with Learning Disabilities said that carers who have their older children living at home have found it difficult to be recognised as needing help with shopping and accessing food delivery slots.¹⁰¹

182. A number of individuals who responded to our consultation told us that, despite having received a shielding letter, they had struggled to obtain any help:

“My husband is 72 and disabled and also shielding. We have not been given any help or support. When I made an enquiry for assistance at the council, they told me the help was only for those who were struggling financially, I was only given the telephone numbers of charities who might arrange shopping. We have however managed for ourselves using the Internet for our supplies.”¹⁰²

183. We also heard that the local authority food boxes, although welcome, did not take account of the special dietary requirements of many vulnerable people:

“The box contained mainly wheat products and some high sugar products. Both my mother and I are wheat intolerant (the consumption of wheat causing us both varying painful and debilitating effects) and my mother is diabetic which is controlled with diet.”¹⁰³

184. In relation to medicines, pharmacies have reported seeing significant increases in medicine deliveries. The Royal Pharmaceutical Society raised the issue of sustainability around the delivery service, particularly if the high level of demand continues into the winter months.

¹⁰⁰ Written evidence, C16

¹⁰¹ Written evidence, C43

¹⁰² Written evidence, C42

¹⁰³ Written evidence, C33

Longer term support

185. We have received evidence from a number of respondents concerned about the guidance services that will be available longer term for those who are shielding, and their families. Parkinson’s Cymru said it believed that the Welsh Government and NHS Wales should be “planning on a longer-term basis to help those shielding to access healthcare”:

“It is crucial that clear guidance on attending face-to-face appointments with appropriate informal support for those who need it will be essential to reduce anxiety and ensure people who need to, can attend appointments.”¹⁰⁴

186. The Motor Neurone Disease Association said that, with the easing of lockdown, vulnerable people, their carers and families, will face “difficult decisions” around managing the risk of contracting Covid-19. This, it said, was compounded by ongoing uncertainty over what measures will be in place to support people to manage that risk:

“A major cause for concern is whether carers and family members of people vulnerable to COVID-19 will be expected to return to the workplace, potentially risking contracting the virus and passing it on to a vulnerable person at home.

The Welsh Government should issue clear guidance on the easing of shielding guidelines including anticipated timelines and detailing what support will be available to help the families and carers of vulnerable people during this difficult period.”¹⁰⁵

187. Similar points were made by the Asthma UK and British Lung Foundation Partnership.¹⁰⁶

Our view

188. It is our view that the need to shield extremely vulnerable people is an admission of failure by governments in managing this disease. It came about as a direct result of the change in early policy from containing the virus (involving a test-trace-isolate approach) to delaying its spread. While the initial approach

¹⁰⁴ Written evidence, C30

¹⁰⁵ Written evidence, C40

¹⁰⁶ Written evidence, C16

focused on preventing the spread of the virus, the latter inevitably accepted that the infection would be widespread and that the most vulnerable people, therefore, had to be totally isolated for a prolonged period.

189. Significant demands have been placed on the population as a whole during this pandemic and, for those in our communities who are most vulnerable, it has been a particularly difficult and frightening time.

190. It is therefore unfortunate that, during a period when clear communication was needed with those being asked to shield and their families, this was not always delivered. While we recognise the logistical challenges involved in implementing the policy, delays early on in the issuing of shielding letters caused uncertainty for many. This was compounded by the later discovery that around 13,000 letters had been issued to incorrect addresses, and we are very concerned by this breach of patient data.

191. There has been confusion about the role of GPs in the process, particularly as they did not initially have access to the shielded patient list or to the shielding letters. This confusion persists to a degree even now, with anecdotal evidence of varying approaches taken by different GPs to adding people to the shielded patient list, and concerns by some third sector organisations that GPs will remove people from the shielding list without consultation with their specialists.

192. We have also been concerned by a limited number of reports of poor handling of sensitive conversations between GPs and certain patients relating to advanced care planning and, in particular, Do Not Resuscitate forms. These were the source of much unnecessary distress to those involved.

193. Moving forward, it is important that communication with this group is strengthened so that they feel fully supported, and that they are not being left behind or left unprotected as wider restrictions for the general population are eased.

194. Further, the Welsh Government needs to consider the mental health impacts of the shielding policy on this extremely vulnerable group of people, and look at how best to mitigate their effects through the provision of detailed guidance and support.

Recommendation 11. The Welsh Government must take steps to:

- ensure there are no further breaches of patient data going forward, and

- better communicate with people who have been advised to shield. This needs a clear, well-structured, responsive, timely and transparent approach, and must be an integral part of the future strategy for support to this very vulnerable group of individuals.

195. More broadly, we are not persuaded that the decision to link the receipt of a shielding letter to the provision of services, like online food shopping and delivery of medicines, has proven to be wholly effective. For a great many, it has been the source of considerable and on-going anxiety, particularly so during the earlier part of the lockdown when major supermarkets in England had been provided with the details of those shielding but this was not the case in Wales. The Welsh Government should have been working more swiftly and proactively with these supermarkets during this time to increase capacity and to take the pressure off those who were shielding.

196. If this system is to continue longer term, we feel there is a need for it to be better organised, not least to ensure there is capacity in the system for those people not on the shielded patients list but who are otherwise vulnerable and have previously made use of online shopping services but find they are unavailable now. We feel this will be particularly important during the coming winter months, when there will inevitably be greater demand for these services.

197. We also wish to highlight the increased demands for delivery of medicines during the lockdown, and concerns about the ongoing sustainability of these delivery services during the winter period.

Recommendation 12. The Welsh Government must re-examine the arrangements with major supermarkets to ensure it can satisfy itself that there will be sufficient capacity for online food shopping and home delivery to meet demand, particularly during the coming winter period.

Recommendation 13. The Committee recognises that there is a cohort of people not on the shielded patients list who are otherwise vulnerable or normally rely on online food shopping and delivery services. The Welsh Government must look at how best to identify and offer support to these people.

Recommendation 14. The Welsh Government should commission a focused and rapid review of the current arrangements for delivery of medicines to ensure they are robust, reliable, safe and sustainable, and able to meet both current demands and potential future pressures, especially during the winter months.

198. Throughout this period, the role of local government in providing support to people who have been advised to shield has been critical. Across Wales, councils

have worked tirelessly to identify and respond to the needs of their communities, re-configuring existing services, putting additional support in place and re-deploying staff where they could. There have been some teething problems, but given the scale of the challenge and the limited time within which it was to be completed, their collective achievements have been remarkable.

199. Moving forward, there must now be an opportunity for local authorities to review the arrangements they have put in place to ensure they continue to be both effective and efficient. This needs to include consideration of the long-term viability of support from local authorities when redeployed staff return to their main roles.

Recommendation 15. The Welsh Government must work in partnership with local authorities to review existing support arrangements for shielded people, and implement improvements as necessary.

200. Longer term, as restrictions ease and the NHS seeks to re-instate more routine services, there will be a need for clear guidance and support for those who have been shielding about how to access a full range of healthcare services safely.

201. Additionally, there will be a need for clear guidance for, and communication with, family members and carers of those shielding about any further easing of restrictions and being asked to return to the workplace.

Recommendation 16. The Welsh Government must ensure that there is clear guidance made available to those who are shielding about accessing routine healthcare services and how to do this safely.

Recommendation 17. The Welsh Government must ensure there is clear guidance provided for families and carers of people who are shielding about returning to work, and the support they can expect.

6. Test, Trace, Protect Strategy

The Welsh Government has said that contact tracing ‘will need to be maintained at a significant level, potentially for the next year or until a vaccine is found’.

Objectives and governance

202. On 13 May, the Welsh Government published its Test, Trace, Protect (TTP) strategy.¹⁰⁷ It notes that testing has, until recently, focused on people in hospitals, care homes, and symptomatic critical workers. In the next phase, the TTP strategy will mean asking people to report symptoms; testing anyone showing symptoms of coronavirus; and tracing those they have come into close contact with.

203. Testing and tracing under TTP has a number of key purposes, including diagnosing the disease to help with treatment and care; population health surveillance, to understand the disease spread, clusters and hot spots; contact tracing in order to control the spread of the disease; and business continuity, enabling key workers to return to work more quickly and safely.

204. The Welsh Government has said that delivering the TTP strategy will require partnership working, with roles for Public Health Wales, LHBS, local authorities, third sector, academia, local business and other partners.

205. In terms of the overall governance for the TTP process, Dr Giri Shankar from Public Health Wales, confirmed that the Welsh Government’s Strategic Oversight Group is responsible for overseeing the delivery of the TTP strategy. The Group is chaired by Jo-Anne Daniels, Director of Mental Health, Vulnerable Groups and NHS Governance.¹⁰⁸

206. He further confirmed that the operational implementation of contact tracing is organised at three levels: the national tier, the regional tier and the local tier:

“The regional tiers have taken responsibility for the delivery at the region. That is a joint effort between the health boards, as well as the

¹⁰⁷ Similar strategies have been launched across the UK. The NHS England test and trace service commenced on 1 June. The Scottish Government launched ‘Test and Protect’ on 26 May. The Northern Ireland Government launched its ‘Covid-19 Test, Trace, Protect Strategy’ on 28 May.

¹⁰⁸ RoP, 12 June 2020, paragraph 18

local authorities, with specialist input from Public Health Wales as expert health protection staff.

And at a national level, Public Health Wales is undertaking a co-ordinating function of providing the necessary support, as well as the expertise, as well as the human resources to these structures.”¹⁰⁹

207. Finally, he stated that, in complex situations, and where contact tracing is needed in, for example, prisons, Public Health Wales is undertaking that role.¹¹⁰

208. Sir David King, Chair of Independent SAGE, was very critical of the delay in introducing a system of contact tracing across the UK. He said:

“We have come to test and trace too late. (...) Every other country in Europe (...) has got a good operative test and trace system; we haven’t.”¹¹¹

(...) everyone surely knows that—especially once you’ve gone into lockdown, but even before you go into lockdown—you need to know where the disease is, you need to be tracing, testing and isolating people. To come into it in the late period of the close-down just seemed to us to be irresponsible.”¹¹²

209. The BMA, while welcoming the publication of the strategy, stated:

“it is clear that more detail is required, at a rapid pace, due to the scale of the infrastructure, technological rollout and recruitment exercises that need to be put into place to realise this strategy. Development should be guided by public health principles and make best use of the clinical and epidemiological expertise in Wales’ public health doctors. Additionally, the rapid operationalisation of the plan would be aided through social partnership work alongside trade unions.”¹¹³

210. In his most recent evidence to this Committee, the Minister for Health and Social Services told us that, after three days of the TTP system being in place, he was:

¹⁰⁹ RoP, 12 June 2020, paragraph 18

¹¹⁰ RoP, 12 June 2020, paragraph 18

¹¹¹ RoP, 18 June 2020, paragraphs 21, 105

¹¹² RoP, 18 June 2020, paragraph 102

¹¹³ Written evidence, C27

“really encouraged and cautiously positive (...) that this new national NHS Wales test, trace and protect service is doing what we wanted it to do..

We’re in a position where we have fewer than 100 positive cases to follow up each day (...) and we’re in a position where I think the two-week trial has really served us well, and the training that we’ve provided to staff in that time and the learning that people have shared, I think, has been really important.”¹¹⁴

211. The Minister confirmed that he intends to publish, on a weekly basis, “figures on not just the numbers of people that come in, but some of the caveats around that as well”.

“So, for example, I said we had fewer than 100 positive cases confirmed each day, but, for some of those, contact tracing won’t take place. So, for example, people in a care home—it’s a closed environment, we haven’t got visitors going in.

So (...) in that overall figure, we’ll then need to provide a different figure for the number we’d want to follow up contacts for, and we’ll then need to indicate something about the amount of activity that takes place on contact tracing.”¹¹⁵

212. He confirmed that discussions were underway with other governments in the UK about common areas of activity to measure to enable comparisons between the nations.¹¹⁶

Pilot projects

213. A number of pilot projects, designed and delivered jointly by LHBs and local authorities, have been running in Hywel Dda, Powys, Betsi Cadwaladr and Cwm Taf Morgannwg since 18 May.¹¹⁷

214. The Chief Executive of NHS Wales has reported some learning points from the pilots, including the challenge of scaling up the projects, as well as the

¹¹⁴ RoP, 4 June 2020, paragraph 110

¹¹⁵ RoP, 4 June 2020, paragraph 111

¹¹⁶ RoP, 4 June 2020, paragraph 112

¹¹⁷ Written statement by the Minister for Health and Social Services

necessity of a partnership approach. We have also discussed learning points with Public Health Wales, and Ceredigion and Ynys Môn County Councils.

215. Public Health Wales told us that the main learning had involved fitness for purpose of the contact tracing scripts; how best to undertake tracing in a care home setting; and how to identify issues with contacts. On this last point, Dr Giri Shankar stated there has been problems in the early pilot period where results coming via laboratories did not have contact telephone numbers. He confirmed that this had been resolved and “we’re now getting a higher proportions of contacts with telephone numbers, which makes it easier to contact”.¹¹⁸

216. Dr Shankar confirmed that these learning points had been implemented in phase 1 and phase 2 of the tracing process.¹¹⁹

217. Prior to the implementation of these pilot schemes, Ceredigion County Council had developed and piloted its own system of contact tracing. Barry Rees, Corporate Director told us that the decision to develop the model had been:

“... based on global evidence that tracing systems could have a positive impact, bearing in mind that our numbers were very low, and therefore a contact-tracing system could be effective, given where we were in terms of the number of cases at that time—that’s an important context.

We weren’t in crisis mode and we did have some scope to create a (...) home-made system, using the expertise of our colleagues within public protection (...) who [had] some expertise in similar contact-tracing systems because of their functions in terms of tracing things like legionella, food poisoning cases and so on.”¹²⁰

218. They were also supported by their ICT department to create a system to gather and analyse the data collected.¹²¹

219. More broadly, the Chief Executive of Ceredigion County Council, Eifion Evans said that one key lesson from the pilot had been about testing and the capacity for this:

¹¹⁸ RoP, 12 June 2020, paragraphs 14-15

¹¹⁹ RoP, 12 June 2020, paragraphs 14-15

¹²⁰ RoP, 12 June 2020, paragraphs 233 and 236

¹²¹ RoP, 12 June 2020, paragraphs 233 and 236

“I think what we need to be absolutely crystal clear on is, ‘Let’s test for the virus at this precise moment in time, make sure that we invest in a national CRM [customer relationship management] system that is robust and is easily accessible to all, let’s analyse that data very, very effectively moving forward, and get this contact tracing system well established, and get the skill set.’ If we can get those component parts in place urgently at the right time, we’ll not only suppress this virus, but we can eradicate it from Wales, because the desire is there to do so.”¹²²

220. He said it was critical not to look backwards and try to recover lost ground:

“once you start introducing the new track and trace system, take that as your baseline and take any fresh new cases and attack those, and the more that you can attack those, and the earlier you can attack them, the better.

(...) as an example: Cardiff would never cope with going to address the 2,000 plus infections in Cardiff at this precise moment in time. But, if you look at their daily infection rates, their daily infection rates are down to single-figure numbers. That’s a very manageable figure to deal with. So, go after those and keep going after the daily ones, and, if we’re going to take that approach, I think our infection rates across Wales at the moment are low enough for the contact tracing system to work. (...) it would be a waste of a huge amount of effort and resource to go back after all the high numbers. Leave those alone. Go after the daily ones.”¹²³

Testing capacity

221. The Strategy describes the scale of testing capacity to support TTP as ‘unprecedented’, requiring laboratory capacity for up to 10,000 tests a day initially, enabling testing of more key workers, and those receiving care in hospitals and care settings. That capacity is planned to increase to 20,000 tests daily by the end of July 2020, drawn from Wales and a share of the UK-led testing programme.

222. As regards domestic capacity, the Chief Executive of Public Health Wales, Dr Tracey Cooper, said “we feel comfortable that we can get to 15,000 [tests]”. She said there are “large sustainable platforms that we have in place” and that there

¹²² RoP, 12 June 2020, paragraph 272

¹²³ RoP, 12 June 2020, paragraphs 315-316

were “further pieces of equipment coming in from South Korea, going around Wales”.¹²⁴

223. Further, she told us :

“there is an untapped additional capacity through home testing and through the lighthouse labs, where samples are sent over to England capacity. So, that gives us a comfortable space to get up to that 20,000.”¹²⁵

224. She also said that discussions were taking place “to see whether or not there’s a potential for such a lab [UK Lighthouse Labs] coming to Wales”.¹²⁶

225. In relation to the Lighthouse labs, Professor Deenan Pillay from Independent SAGE told us that there was now an opportunity to consider what the future of testing for the next wave will look like. He said:

“The lighthouse laboratories that have been developed are themselves dependent on volunteers staffing them who’ve come because (...) they’re no longer able to do the research they were doing in universities because of the lockdown. Equally, machines that have been used have been taken from universities to put into these lighthouse laboratories. That is all going to come to an end because we’re going back, releasing lockdown.”¹²⁷

226. He confirmed that, in his view, there is an urgent need to plan for migration of testing back from the emergency Lighthouse laboratories into a more integrated future “normalisation” of such increased capacity across existing public health/NHS laboratories.¹²⁸

227. In his statement on 10 June, the First Minister confirmed:

“Last week the highest number [of positive cases of coronavirus] on any one day was 82, the lowest 35. These cases generated 651 people for follow-up by the contact tracing teams, of whom 619 have been successfully contacted and advised.”

¹²⁴ RoP, 12 June 2020, paragraph 88

¹²⁵ RoP, 12 June 2020, paragraph 88

¹²⁶ RoP, 12 June 2020, paragraph 88

¹²⁷ RoP, 18 June 2020, paragraph 116

¹²⁸ RoP, 18 June 2020, paragraph 116

Turnaround of testing

228. Advice from the Technical Advisory Cell (TAC) states:

- Countries with successful schemes have low case numbers and don't focus on capacity; speed of testing and tracing is more important;
- Schemes perceived to be most successful require tests results within 24 hours and contact tracing to be complete within 24-36 hours. Comparators report 75-90 per cent of contacts need tracing for TTP to be effective.

229. The figures on delivery of test results for 21 June in Wales report only 64 per cent of hospital tests were delivered within 24 hours, with a lower percentage for community testing and drive through facilities. Results for home testing kits are not reported, although [guidance on home testing](#) indicates that it may take up to 72 hours for a home test.

230. In their most recent evidence to this Committee, Public Health Wales stated that the 'end-to-end time'¹²⁹ for testing in Wales within 24 hours is 52.1 per cent, as of 10 June. Within 48 hours it is 85.6 per cent. The Chief Executive of Public Health Wales said this is "more favourable than in other parts of the UK on some of the UK testing".

231. A number of witnesses have highlighted the importance of the timely return of test results to the success of the TTP strategy. On this point, Sir David King, stated:

"the turnaround time after testing is critically important. If you get the test result five days after the test is made, and that person is still wandering around in their community, imagine the number of people infected during that period. It's critically important that the timeline between the test being drawn and completed, and the information going through, is as short as possible."¹³⁰

232. Similarly, the WPGA told us:

"(...) if we are doing testing, we need the results back quickly, because if we are to trace the individuals that that person's had contact with,

¹²⁹ 'End to end time' is the time from when an individual presents at a testing centre and their details are entered into an electronic test request to the completion of the laboratory processing.

¹³⁰ RoP, 18 June 2020, paragraph 136

while the individual is supposed to isolate until the results come back (...) and if they think, 'Well, I only had mild symptoms; I don't think I had it', by day three they may decide to go back to work, or they may decide to carry on with what they do.

So, we need to make sure those test results come back, because, otherwise, our tracing job of maybe tracking and tracing five, six, seven individuals could become tracing 30 or 40 individuals, and the whole system then would fail.

(...) the one part that we can't control is (...) the actual test being done in a timely way and the result coming back. We have to rely on others for that, and that's the part that we need to make sure we have absolute confidence in."¹³¹

233. There have been calls for more locally-based testing facilities in Wales to support a quicker turnaround of tests.¹³² On this point, the Chief Executive of Public Health Wales told us that, by the middle of June and by early July, six new pieces of equipment should have arrived from South Korea which will "considerably improve our local turnaround time" by enabling more testing to be completed locally. She confirmed that "two pieces of equipment will be going into north Wales, a couple into west Wales, and then a couple in south Wales".¹³³

Starting the process

234. Currently, contact tracing in Wales begins once a positive test result has been returned. We questioned the Minister about whether this was as a result of capacity within the system, or based on advice about the best way to proceed. He confirmed that "the advice we have is that if we can move to a system where we can trace on symptoms, that would be ideal (...)".

235. He said he wanted to be in a position in the future to trace on a positive result or someone who is waiting 48 hours, but acknowledged that there may be cases that fall outside that 48-hour window. He went on to say that he "want[ed] to be able to move to a position where, in the future, we can contact trace even if people haven't had their test results".

¹³¹ RoP, 21 May 2020, paragraph 80

¹³² Including from the Leader of Ceredigion Council, Councillor Ellen ap Gwynn, [BBC interview](#)

¹³³ RoP, 12 June 2020, paragraph 114

“We’re looking for a system that is effective but meets the advice and the guidance we’ve got, and provides for 80 per cent of the contacts to be traced and followed up, because that’s the high watermark that we’ve been given by Dr Orford and his colleagues on the technical advisory group for a properly effective, robust contact tracing system.”¹³⁴

236. We questioned the Minister further about the time taken for test results to be returned, and the 48-hour window. He stated:

“The numbers are small enough now that we’re able, with our group of 600 staff at present— where we should have some confidence in being able to follow up those contacts to the degree that we need and at the speed that we need. But that does (...) rely on the speed of the testing programme in turning around the results.”¹³⁵

237. Based on their own experience, Barry Rees from Ceredigion County Council was clear that “one important thing is the starting point for contact tracing”. He said that, as a major employer within the County, their access to information about their employees who were displaying symptoms but had not necessarily been tested meant they had been able to start the contact tracing process even before testing:

“the fact that we were able to pick up some individuals—our staff, in this case—at a symptomatic point, rather than awaiting a positive result—I think that had been very beneficial in terms of cutting any delays in turning this process around.”¹³⁶

238. Professor Deenan Pillay, however, was less convinced about tracing on symptoms. He suggested that such a system could lead to tracing and quarantining being in excess of what is needed, in cases where an individual had flu-like symptoms but they were the result of another virus or infection:

“One of the real problems is that even at the height of the pandemic, we estimated that probably (...) only 20 per cent to 30 per cent of those individuals with these sort of flu-like symptoms (...), even at the peak, would be due to COVID, because there are other viruses and other infections circulating.”

¹³⁴ RoP, 4 June 2020, paragraph 116

¹³⁵ RoP, 4 June 2020, paragraph 118

¹³⁶ RoP, 12 June 2020, paragraph 237

239. He said:

“I think we need to make sure that testing is there—that even if we start isolation based on symptoms, we need to get results of tests back very quickly (...) in order to not mean unnecessary quarantining of contacts, which could become a huge number.”¹³⁷

Resources and funding

Resources

240. The TTP Strategy will require a workforce of up to 1,000 staff, drawn from Public Health Wales, local authorities and LHBs. They will be specialist public health professionals and non-specialist administrative staff. The Chief Executive of NHS Wales reported on 28 May that the full 1,000 will not all be required initially, but 600 staff had already been recruited.

241. In evidence to this Committee, the Leader of the WLGA said that, while he was confident there were sufficient staff currently available to manage the task, it “becomes an issue going forward”:

“If the current stages of lockdown are lifted more and more, and if we get to the stage of more council services being reintroduced, then there is a conflict there, because we won’t be able to use those same staff for tracing if we’re expecting them to reopen services.

So, where we’ll have to backfill staff, there will be significant costs, and we’ve had discussions with the Welsh Government about that to make them aware that this is a multimillion pound, ongoing task, where, at some point, funding will have to come available.”¹³⁸

242. Similar points were made by the Chief Executives of both Ceredigion and Ynys Môn councils.

243. The Chief Executive of Ynys Môn Council, Annwen Morgan, said that Ynys Môn had been redeploying staff to work on contact tracing, but that appointing staff would become a challenge with the easing of lockdown restrictions. In her view, they will need to start gradually, “and not move immediately towards the

¹³⁷ RoP, 18 June 2020, paragraph 141

¹³⁸ RoP, 21 May 2020, paragraph 77

high national numbers". She also highlighted the "valid need for having bilingual people available to do that [contact tracing] work".¹³⁹

244. The Chief Executive of Ceredigion County Council, Eifion Evans, confirmed that, while they had been able to appoint to a number of roles already,

"the scale-up is ongoing. Everything is operational nationally, but we have to recognise that the full capacity isn't in place as of yet."¹⁴⁰

245. Further to this, the Corporate Director suggested there was a need to train more people than might be needed, in order to have the additional capacity within the system to be "agile and responsive" if the situation worsens.¹⁴¹

Funding

246. On 27 May, the Finance Minister published the first Welsh Government supplementary budget of 2020-21, which included an additional £57 million for the "Track & Trace" strategy. The Welsh Local Government Association has already indicated the strategy will require 'significant additional resources' in terms of staffing and funding for it to be successfully delivered:

"Alongside specially trained council public protection officers, and partners in health, other non-clinical staff will need to be either recruited or redeployed to support the mammoth work to manage the disease in local communities.

Welsh Government has recognised that this work will come at a cost, and councils will continue to work with Ministers to explore the implications and the funding required."¹⁴²

247. In our most recent evidence session with Public Health Wales, Dr Quentin Sandifer stated that:

"Welsh Government has recently written to local government and has set aside a total sum of £1 million to be allocated between the local authorities in Wales to help them with the infrastructure costs, and the discussions are ongoing between the Welsh Local Government

¹³⁹ RoP, 12 June 2020, paragraph 259

¹⁴⁰ RoP, 12 June 2020, paragraphs 253-254

¹⁴¹ RoP, 12 June 2020, paragraph 319

¹⁴² Written evidence, C26

Association, local authorities and Welsh Government itself on additional cost and resourcing impacts.”¹⁴³

248. However, the Chief Executive of Ceredigion Council said that councils had not yet had any firm confirmation of additional funding from the Welsh Government. Instead, they had “taken on trust” a message from the Chief Executive of NHS Wales during a recent National Chief Executives’ Forum that this work was “priority No. 1 for the country” and that “the money will follow”.

249. He went on to say:

“The only thing we have received is a modelling document from Welsh Government that would enable us to populate our staffing levels against it. It’s a very complex, complicated tool to administer, but there’s no confirmation about what that would equate to financially at the moment.”¹⁴⁴

250. Separately, the BMA also highlighted the need to “maximise the best use of resources within the Welsh public sector (...) given that it has been estimated that contact tracing teams would identify between 7,500 and 30,000 new contacts per day and 100,000-400,000 individuals being tracked at any one time.”¹⁴⁵

251. It called on all Governments across the UK to assess the current capacity and urgently seek to expand, reinforce and supplement any deficiencies, with adequate funding provided to deliver this programme.¹⁴⁶

Public participation in TTP

252. The TTP Strategy emphasises that the role of the public will be key, and the Minister for Health and Social Services has ~~stated~~ that ‘for it to be successful, we need everyone’s help and cooperation in sharing details about their movements and contacts. We also need people to self-isolate if they may be at risk’.

253. In his evidence to this Committee, the Minister for Health and Social Services described public buy-in as “essential for contact tracing to work”, and for that reason, it was

¹⁴³ RoP, 12 June 2020, paragraph 47

¹⁴⁴ RoP, 12 June 2020, paragraph 295

¹⁴⁵ Written evidence, C27

¹⁴⁶ Written evidence, C27

“really important that it’s an NHS Wales test, trace, protect service. The NHS is still the most trusted public service in the country (...) so, people being contacted by the health service or people working with the health service I think matters, and that’s an agreement from local government and the NHS that that’s how the service is being described, because that’s the reality of the service.”¹⁴⁷

254. He said that there had been a “ready and willing” response from the public thus far in both the trial and the first point of contact tracing, but that it would be necessary to “reiterate to everyone (...) that the damage done from not taking part in contact tracing (...) is likely to be much more significant. (...) we’re talking about a system that we think will help to avoid harm, which includes the loss of life”.¹⁴⁸

255. Similar points were made by the Chief Executives of both Ceredigion and Ynys Môn Councils:

“This has to be part of the new culture of Wales. (...) If we can move the nation to an attitude of where it’s a civic duty to recognise that, if you are not feeling well, if you are symptomatic, you don’t take any risks, self-isolate for an interim period [and] refer yourself for a test urgently.”¹⁴⁹

256. Linked to this is the importance of compliance by the working population. The TTP strategy states:

“Contact tracing means people may be asked to self-isolate multiple times. The more often people come into contact with others, the more likely it is that they will be required to self-isolate. We recognise the strain that this may place on individuals and their families if they are having to isolate on numerous occasions.

We will (...) talk to the UK Government about how they can ensure people are enabled to self-isolate through appropriate provision in terms of individual employment rights and the social security system.”

¹⁴⁷ RoP, 4 June 2020, paragraph 123

¹⁴⁸ RoP, 4 June 2020, paragraph 124)

¹⁴⁹ RoP, 12 June 2020, paragraphs 325-326

257. The GMB has raised serious concerns about the risks to the social care sector due to the workforce being unable to afford to take time off work if they were sick or required to isolate:

“The GMB believes that any worker following a Government instruction to self-isolate should not suffer any financial detriment. SSP is set at £95.85 and is not in any way sustainable for individuals. Therefore, it is highly likely that staff will be forced to ignore your Governments advice and attend work anyway.”¹⁵⁰

258. It also states that the TTP Strategy “makes no reference to how employees get paid for isolating”. As such, it has assumed that those who are informed that they must self-isolate for 14 days would only be entitled to Statutory Sick Pay (SSP), something it says is “unacceptable” and “would put significant risk on the future recruitment and retention of social care in Wales”.¹⁵¹

Use of technology

259. Unlike the UK, other countries across the world have been making use of contact tracing technology from early stages of the outbreak.

260. The Welsh Government has committed to a single digital platform for contact tracing across Wales, which was to be developed by NHS Wales Informatics Service (NWIS) and available across Wales from 8 June. In evidence to this Committee, the Minister for Health and Social Services confirmed that this platform would be in place in the week commencing 8 June 2020:

“That should actually make reporting and providing data to the public easier, as well as then making sure we’re not dealing with the manual workaround we’ve got at present with the very interim solutions. So, next week will be an important point, and then we’ll have several more weeks of that running.”¹⁵²

261. On the development of the system, Dr Giri Shankar from Public Health Wales told us that there were currently 2,000 users registered. He said that some issues

¹⁵⁰ Written evidence, C46

¹⁵¹ Written evidence, C46

¹⁵² RoP, 4 June 2020, paragraph 113

had been identified and resolved, and that a daily “walk-through surgery” was being held with the users to enable troubleshooting.¹⁵³

262. He confirmed that, going forward, there will be a programme management board to look at “all the advisories and all the suggestions that come from the local teams, the regional teams, to further incorporate additional functionality into the system to make it even more user friendly”.¹⁵⁴

263. The Chief Executive of Ynys Môn Council, however, was clear that the system had not been fully operational from the outset on 8 June:

“It has not entirely been rolled out. I’ll give you an example: the super-users, such as our project managers, can’t have access to the system at the moment, and it’s these people, of course, who provide that overview of everything that’s happening.”

“I don’t doubt that we’ll get over these problems, but it wasn’t ready to go as a Rolls-Royce system on the eighth.”¹⁵⁵

Contact tracing/proximity tracking apps

264. The First Minister has indicated that the Welsh Government could also use the UK government’s NHSX Covid-19 app, ‘provided it completes its trial phase satisfactorily’. This app could help with contact tracing by using Bluetooth signals and has been piloted in the Isle of Wight. In his evidence to this Committee, the Minister for Health and Social Services stated:

“The NHSX app could be useful, and what I’ve always said still remains the position: if it works, if the data issues are resolved about the transfer of data into the Welsh system so it’s useful for us, and the privacy issues are resolved, then we want to be part of it. I think that’s the right position to take.”¹⁵⁶

265. He maintained, however, that the app itself is not the “determinant part of whether contact tracing works”, but rather the system already in place.¹⁵⁷

¹⁵³ RoP, 12 June 2020, paragraph 176

¹⁵⁴ RoP, 12 June 2020, paragraph 176

¹⁵⁵ RoP, 12 June 2020, paragraph 344

¹⁵⁶ RoP, 4 June 2020, paragraph 133

¹⁵⁷ RoP, 4 June 2020, paragraph 135

266. Similar points were made by Public Health Wales, who stated that “the app in itself cannot be the answer for contact tracing [but] it can be a supplementary tool” to monitor symptom progression across the population.¹⁵⁸ He said that apps already in use, such as the ZOE symptom tracker, had been “really helpful to gauge how the symptoms are in the population”.¹⁵⁹

267. In relation to proximity tracking apps, like the one trialled on the Isle of Wight, Dr Shankar explained that these worked by sending a digital signal to other users of the app, recognising and retaining a memory of all individuals who have come within 2m contact for more than 15 minutes. If an individual subsequently tested positive, it would then alert all those who had been in contact to enable them to take the necessary steps. He said:

“we see that to have benefit in areas such as, if you are on public transport, you will not know who you’ve been in contact with; if you are in a large public building, you won’t know where you have been. So, in such locations, these apps will actually help provide that signal, but as I said, again, the app in itself is not the answer; it’s a supplementary tool to our other contact tracing systems that we have.”¹⁶⁰

268. On 18 June, the UK Government confirmed that it would not proceed with its current tracing app and would instead “be taking forward a solution that brings together the work on our app and the Google/Apple solution”.

Cross border tracing

269. In his evidence, Dr Quentin Sandifer, Public Health Wales said that “in contact tracing, [data sharing] is essential”. He stated that arrangements had already been established in normal health protection practice to ensure that information about cases and contacts is shared across the border. Further, he said that Public Health Wales had “made absolutely sure that those robust arrangements are established, and indeed that any available technologies that can support us are deployed to enable us to do that”.¹⁶¹

270. We questioned the Minister about progress with the formal protocol for cross-border tracing between Wales and England. He confirmed that there was “agreement between officials about how that should work and how information

¹⁵⁸ RoP, 12 June 2020, paragraphs 180-181

¹⁵⁹ RoP, 12 June 2020, paragraphs 180-181

¹⁶⁰ RoP, 12 June 2020, paragraphs 180-181

¹⁶¹ RoP, 12 June 2020, paragraph 206

should take place with which contact tracing team of follow-up contacts and then how information will be shared between the two different systems”.¹⁶²

271. He said he was “looking to sign off an agreement” about that data sharing, and that could then be a model for future working and interaction with other countries in the UK.¹⁶³

Our view

272. Many countries across the world have implemented their own contact tracing arrangements in response to the Covid-19 pandemic. In the UK, there is a strong history of contact tracing for certain diseases, such as legionella and food poisoning, with Public Health Wales itself involved in contact tracing during measles outbreaks in 2012-13 and 2018.

273. It is clear from the results of these arrangements, and international evidence more widely, that contact tracing is a tried and tested weapon against infectious diseases. In the absence of a vaccine, it is the only real weapon we have.

274. Having initiated a contact tracing system in Wales in the early stages of the outbreak, it was a devastating decision, UK-wide, to subsequently abandon this when the infection rate rose. The key learning outcome from that decision has to be that tracing arrangements must be effective going forward, and must be maintained for the remainder of the outbreak, even at times of highest demand, and if there should be further outbreaks.

275. As restrictions are eased and people try to return to a ‘new normal’, it is imperative that the Test, Trace, Protect (TTP) strategy is fully implemented in order to avoid future outbreaks and further periods of lockdown. The Welsh Government and its’ partners have the opportunity now to ensure that all the necessary arrangements are in place for a well-resourced, efficiently functioning testing and contact tracing system.

Recommendation 18. The Welsh Government must take the opportunity now to review all arrangements to ensure that the scale of the infrastructure, the technological rollout and the necessary recruitment exercises are in place to ensure an efficient and effectively functioning contact tracing system. The system must not be compromised because of a lack of planning, resources or

¹⁶² RoP, 4 June 2020, paragraph 137

¹⁶³ RoP, 4 June 2020, paragraph 137

technology, when there has been time to prepare and important opportunities for learning.

Speed and accuracy of testing

276. The speed of testing, the turnaround of testing results, and the accuracy of those results will be critical to the success of the TTP strategy. The longer the 'end to end' turnaround time from sample collection to reporting of results to individuals, the greater the delay at the point where the disease is most infectious, or the greater the likelihood of unnecessary quarantining in cases where results are negative.

277. Advice from the Technical Advisory Cell states that the most successful schemes require test results within 24 hours and contact tracing to be complete within 24-36 hours.

278. The current turnaround times for results in Wales are unimpressive, with only 50.7 per cent being returned within 24 hours and 84.4 per cent within 48 hours (as of 21 June). Moreover, only 43.6 per cent of Community Testing Unit and 44.7 per cent of drive-through testing centre results are returned within 24 hours. Turnaround times for home testing kits are not monitored. As such, we are not yet in a position where a sufficiently high percentage of tests are being returned quickly enough, at a consistent level across all parts of Wales. It is of particular concern to us that these turnaround times have been in decline recently.

279. In view of this, we are concerned about the Welsh Government's decision not to commence contact tracing until a positive test result has been received. This decision should be reviewed immediately.

280. We believe there is merit in the argument that contact tracing should begin at the point where a person is symptomatic. However, we are unsure of the practicability of such an approach, particularly going into the winter months when it is likely that other viruses with similar symptoms to Covid-19 will be in circulation.

281. Given the importance of having quick test results for the efficiency of the system, we believe that the Welsh Government should, instead, focus on reducing the turnaround time for test results, particularly within 24 hours, and the variability of this in the different regions of Wales.

Recommendation 19. The Welsh Government, working with Public Health Wales, must aim for all test results to be returned within 24 hours.

Recommendation 20. The Welsh Government should move immediately to a system where contact tracing begins either on receipt of a positive test, or within 24 hours.

282. Accuracy of test results is equally important to avoid misdiagnosing people as infected when they are not, and to avoid false negative results which may give people false confidence to end self-isolation and return to their normal routine while still infectious.

283. We have already outlined our concerns about the risks around high false negative rates for home testing kits given the invasive way in which the sample needs to be collected (see paragraph 151).

284. We believe it is preferable for tests to be administered by professionals. As such, it may be necessary to increase the capacity of community testing services in order to reduce reliance on home testing kits.

Recommendation 21. The Welsh Government must ensure there are systems in place to both monitor effectively the false negative rate, and to ensure testing is delivered responsively and flexibly to minimise the false negative rate.

Capacity

285. As regards testing capacity, we note that capacity is planned to increase to 20,000 tests per day by the end of July, and that domestic capacity should account for around 15,000 of these tests.

286. However, the greatest number of tests carried out on any one day has not yet exceeded 3,263 (7 June); roughly a quarter of overall current capability. As such, the full capacity of the Welsh system is unused and untested. We also note there remains considerable regional variation in capacity. Whilst there have been some discussions about the potential for bringing new laboratories to Wales, we hope that all options for making full use of existing facilities in Wales have been fully explored first.

287. Capacity for the additional 5,000 daily tests will come from facilities in England. We have some concerns about the guarantees sought by Welsh Government about the turnaround time for these test results.

Recommendation 22. In consultation with Public Health Wales, the Welsh Government should:

- publish a strategy to increase the number of people presenting for tests in order to utilise more fully the available testing capacity;
- take steps now to provide assurances that 20,000 tests per day will be able to be delivered;
- ensure that safeguards are in place to guarantee that capacity from facilities outside Wales is fit for purpose and sufficient to meet demand.
- ensure that the system is able to respond to increases in demand, and expand to meet these.

Resources and funding

288. Contact tracing is resource intensive. The Welsh Government has committed to having 1,000 contact tracing staff in place, although this capacity will take time to build, and all positions have not currently been filled. It is also important to note that, in many local authorities, staff currently working on contact tracing have been redeployed from other roles and will, presumably, need to return to those roles as wider services are gradually reinstated, or their previous positions will have to be back-filled.

289. Either way, a significant programme of recruitment will need to take place, and this will inevitably involve additional expenditure. There are real strengths in local knowledge and experience in contact tracing; this is an area in which local authorities and primary care have expertise and any future arrangement should build on this.

290. As restrictions continue to be eased, we must be prepared for a possible increase in the rate and number of infections, and an important part of this is having confidence that sufficient numbers of staff have been identified, trained and placed as contact tracers. Such training needs to prepare staff for the sensitive nature of the conversations with those they are tracing. Further, it will be necessary that additional, flexible resource is built into the system to enable it to respond to spikes in infection rates, and more local need.

291. We have yet to be convinced that 1,000 staff will be enough to enable the contact tracing system to function effectively at all times, particularly when demand is at its highest.

Recommendation 23. The Welsh Government must, as a matter of urgency review its decisions about the number of staff needed for contact tracing in order to assure itself and the public that the system will be able to function effectively at times of highest demand, and can flex and respond according to changes in demand. It should publish the results of the review.

292. Linked to this is the matter of funding. There is an urgent need for certainty for local authorities about the financial support that the Welsh Government will be making available to support the tracing system, over what could be a sustained period of time.

Recommendation 24. The Welsh Government must confirm, as a matter of priority, the financial support package for local authorities to support the employment of professional tracers, rather than depend on redeployment of existing staff..

Trust and compliance

293. Public trust in, and compliance with, the TTP strategy will be vital. The strategy itself acknowledges that people may be asked to self-isolate multiple times, and this may place strain on individuals and their families.

294. There will be a need for clear and repeated public messaging about the social responsibility that every person must take in self-isolating on symptoms and referring themselves urgently for testing.

Recommendation 25. The Welsh Government, working with its partners, must ensure a system of clear and repeated public messaging – at a national and local level - about individual responsibilities to self-isolate on symptoms, and the importance of urgent self-referral for testing.

295. For many, the financial strain of the last few months may lead to pressure to ignore symptoms and advice, and attend work. There are significant risks here in terms of the social care workforce who, despite performing a crucial service, do not enjoy parity of terms and conditions with their health service colleagues. If these workers have to rely on statutory sick pay (SSP) during repeated periods of self-isolation, this will put great strain on them and their families, as well as the wider social care workforce. This is an area that requires urgent attention from the Welsh Government, particularly given the non-devolved nature of SSP arrangements.

Recommendation 26. The Welsh Government must pursue with the UK Government the arrangements for statutory sick pay for social care workers in Wales required to self-isolate. This should be done urgently.

Use of technology

296. We note that the single digital platform for contact tracing across Wales was available from 8 June, and that arrangements are in place for a programme management board to monitor its ongoing development.

297. We are interested in the progress and performance of this system going forward, and trust that this information will be put in the public domain.

298. As regards contact tracing and proximity tracking applications, there has been much speculation and media coverage about the various options that could be available. We agree that any future use of such apps would be a supplement to the contact tracing system, rather than a replacement for it or an essential element of TTP.

Cross border arrangements

299. As regards cross-border arrangements, these will become increasingly important as restrictions across the UK are eased and we see greater movement of people into and out of Wales.

300. We understand that there is agreement between officials about how this will work between Wales and England, and that the Minister hopes to be able to sign off a protocol enabling and supporting this. We would welcome further information about this protocol, including details of how it will operate and when it will commence officially. We would also like to have more information on the progress of discussions with the other UK nations towards information sharing protocols.

Recommendation 27. The Welsh Government must provide further information about the protocol on cross-border arrangements.

301. We welcome the confirmation from the Minister that discussions are underway with other governments in the UK about common areas of activity to measure to enable comparisons between the nations. We would be grateful to receive further information about the progress of these discussions, and notice when they are completed.

7. Financial implications for local government and funding for adult social care

“It will take a generation for Welsh councils to pay for the coronavirus pandemic”¹⁶⁴ according to the WLGA.

Increased costs and lost revenue

302. During the first three months of the outbreak, local authorities in Wales estimate that they have built up a deficit in the region of £173 million as a result of lost income and increased costs.¹⁶⁵

303. In terms of increased costs, the leader of the WLGA, Councillor Andrew Morgan, told us that these had been “significant”, particularly in social care following the influx of additional people from hospital into care homes at the start of the outbreak.

304. Further, he referred to cost pressures caused by local authority staff who have either self-isolated with symptoms themselves or as a result of a family member having symptoms. This, he said, had meant the need to “bring in substantial extra resources in terms of human resources to cover these positions, and it will be mirrored in the independent sector”.¹⁶⁶

305. He also referred to the “significant revenue and capital commitment” from local authorities in converting council-owned premises into field hospitals.

306. He said that additional funding from the Welsh Government for social care had been particularly welcome, and meant that local authorities “do have a mechanism in place to meet the new cost pressures”.

307. However, he said that the issue now facing local authorities was the substantial loss of revenue, not just in the last three months, but also in the months to come:

“Although some of these venues, such as leisure centres for example, would be closed in the current period due to the lockdown, when

¹⁶⁴ [Coronavirus: Councils will take 'generation' to pay for response](#), BBC Wales, 26 May 2020

¹⁶⁵ RoP, 21 May 2020, paragraph 13

¹⁶⁶ RoP, 21 May 2020, paragraph 15

restrictions are eased and these facilities or venues might be re-opened it is unclear how long some of the field hospital conversions will be required to remain in place.

Losing such income generating council assets for a prolonged period of time will therefore have a longer-term impact on council revenue.”¹⁶⁷

Funding for social care

308. On 14 April, the Welsh Government announced an additional £40 million to support adult social care services during the pandemic. The funding was to help meet the increased costs of basic PPE, food, staffing costs and ICT, which were being incurred by adult social services. The Minister said:

“The Welsh Government has been working with local authorities and other partners to identify the additional resources needed to meet the extra demands on adult social care services. We will review this allocation and potentially make further money available if needed in the future.”¹⁶⁸

309. The £40 million will be allocated to local government through the new Covid-19 local government ‘hardship fund’. Local authorities will work with adult social care providers to draw down the extra funding based on the new costs that are identified.

310. A number of witnesses, including the WLGA and Care Forum Wales, referred to the fragility of the care sector in Wales prior to the pandemic, saying that this problem has been exacerbated by the outbreak.

311. In its evidence, Care Forum Wales made clear that the current crisis “comes on top of the chronic under resourcing of the care sector for a number of years and is blasting wide open the cracks in the system”.

312. On this point, their Chief Executive, Mary Wimbury, told us:

“... we’re a sector that needs to keep running, keep caring for our most vulnerable citizens. The sector, as you know, was already in a vulnerable situation, with difficulties in recruiting and retaining staff, widely

¹⁶⁷ WLGA written evidence

¹⁶⁸ [Extra £40m to support adult social care in Wales](#) - 14 April 2020

recognised as underfunded, and we've gone into this crisis in that situation."¹⁶⁹

313. When giving evidence on 7 May, Care Forum Wales welcomed the additional £40 million funding but told us that “little of this money has actually been distributed as guidance was not issued until 27 April”. It went on to say:

“Despite this guidance saying local authorities should ‘provide funding where appropriate, in a timely manner as and when they are aware of them and not delay dealing with these due to the timing of claims to the hardship fund’ a number of local authorities are still considering the way forward, suggesting rigid timetables and incorporating significant bureaucracy into their processes.”¹⁷⁰

314. Mary Wimbury told us that they would have preferred a “national distribution scheme” because “this money isn’t getting to the front line”:

“(…) we are in discussion with local authorities and with health boards for the clients that they fund. (...) In some of our nursing homes over half of the residents are commissioned by health boards, and there’s been a lack of clarity about whether the £40 million was supposed to cover that (...). We heard this morning it will be down to health boards to fund their clients, and local authorities, out of the £40 million, to fund the social services clients.”¹⁷¹

315. She also said that some local authorities were reluctant to spend their promised allocation because the claims-based system meant they did not receive the money up-front:

“The guidance that did come out said that authorities shouldn’t wait until they’ve got the money from Welsh Government; they should pay on the basis of the guidance But I’ve seen an e-mail (...) from some local authorities saying that they are not prepared to do that until they’ve got confirmation they are getting money to cover those claims and got that actual money.”¹⁷²

¹⁶⁹ RoP, 7 May 2020, paragraph 169

¹⁷⁰ Written evidence, C45

¹⁷¹ RoP, 7 May 2020, paragraph 170

¹⁷² RoP, 7 May 2020, paragraph 178

316. Care Forum Wales argued that, moving forward, there was “a need for a better solution to create a robust and sustainable sector to care for our most vulnerable citizens”.¹⁷³

317. The WLGA also welcomed the additional £40 million funding, but noted that it only covers the period from March until the end of May 2020:

“Local authorities will need to understand what further funding is available at the earliest possible opportunity and to monitor that the £40m is sufficient, as some providers, if they face reduced number of clients, will not be able to carry on without guaranteed funding levels.”¹⁷⁴

318. Councillor Andrew Morgan confirmed that all local authorities are currently working with independent care providers to “establish the genuine cost pressures”:

“Because what we don’t want to be doing is funding independent care homes to the full occupation level where, maybe, there’s obviously a profit margin in there. What we need to do in the short term is make sure that they don’t go under and that they remain viable. So, it’s getting the balance right and that is something that’s being reviewed at present.”¹⁷⁵

319. Councillor Huw David said there had been an acknowledgement by the Welsh Government that the £40 million “won’t be enough”, that “they have indicated that this is an initial payment”, and that costs will continue to rise as demand for services increases in the coming months.¹⁷⁶

320. On this point, Councillor Morgan stated:

“All these sums we’re talking about—the loss of income, the additional cost pressures, social care money—these are the first three months’ worth, and I have to say the first three months is fast coming to an end. We are now into the last month, in effect—only a few weeks away from the end of the 13-week period—and we are already now starting in the WLGA to look at what the costs will be for the next three months. We’re

¹⁷³ Written evidence, C45

¹⁷⁴ Written evidence, C26

¹⁷⁵ RoP, 21 May 2020, paragraph 40

¹⁷⁶ RoP, 21 May 2020, paragraph 32

hoping the cost pressures will reduce and we're hoping the loss of income will reduce so that the gap narrows, but there will be a further substantial gap for the coming three months.¹⁷⁷

Our view

321. Local authorities in Wales have been an integral part of the response to this outbreak, providing vital services and support to their communities in the most difficult of circumstances.

322. The cost of the outbreak to local government over a relatively short, three month period is extraordinary and is the result of both lost revenue and vastly increased costs, including in the provision of adult social care.

323. Private care providers have also faced mounting financial pressures during this time, partly due to increased costs but also as a result of falling occupancy rates, as residents passed away and homes were fearful of accepting new residents, particularly on discharge from hospital. This is due, in part, to the earlier lack of availability of testing in care homes, and the lack of testing of residents following discharge from hospital.

324. These problems have served to exacerbate an already fragile sector and jeopardise its long term security further. It is imperative that action is now taken to address them.

325. We were deeply concerned to hear reports that, without financial assistance, a number of care homes are facing closure. Such closures would have a devastating impact on residents and their families, and would put further pressure on the NHS and other services. This cannot be allowed to happen; care homes should be supported to prevent sudden closures.

326. Whilst there has been a welcome injection of £40 million of additional funding from the Welsh Government to support adult social care providers, there has been a recognition that it would not cover the costs of the first three months, and that costs will continue to rise over the coming months as demand for services increase and financial pressures remain. Despite this, local government has still not received clarification from the Welsh Government about the financial support that will be available to them for the next three months and beyond.

¹⁷⁷ RoP, 21 May 2020, paragraph 37

327. The contribution of local authorities and those providing adult social care services should be recognised, in the short term, by a guaranteed funding commitment from the Welsh Government to support service delivery over the next three to six months, as a minimum.

Recommendation 28. The Welsh Government must, as a matter of urgency, put in place a short-term, guaranteed funding commitment to support adult social care services to mitigate the financial impact of Covid-19. This commitment must be developed in consultation with service providers, including local government.

328. More broadly, there is a pressing need for system reform and a long-term, sustainable funding arrangement for social care that fully recognises the importance of the service and the staff working within it.

Annex: Timeline of key events relating to health and social care

The full timeline of the Welsh and UK governments' response is provided in the [Senedd Research blog](#).

January 2020

- The first UK coronavirus cases are confirmed. The [UK Chief Medical Officers advise](#) an increase in the UK risk level from low to moderate. However, it is made clear that “this does not mean [they] think the risk to individuals in the UK has changed [...] but that the UK should plan for all eventualities”.

February 2020

- The UK Government launches a [public information campaign](#) to advise on how to slow the spread of COVID-19. The Welsh Government [says](#) it is working with Public Health Wales to support the campaign.
- The first case of coronavirus in Wales is [confirmed](#). The patient had travelled back to Wales from northern Italy.

March 2020

- The UK Government publishes its [Coronavirus action plan: a guide to what you can expect](#). This joint action plan between the UK Government and devolved Governments in Wales, Scotland and Northern Ireland sets out a phased response to the virus.
- A special meeting of the Welsh Cabinet is held and the Health, Social Care and Sport Committee receive a briefing from the Director General of Health and Social Services and NHS Wales' Chief Executive, the Chief Medical Officer, and Public Health Wales' lead.
- The [UK Government confirms](#) there will be a COVID-19 emergency bill, as part of the UK's phased response to the virus. The legislation, which will apply across the four UK nations, [will provide Wales with emergency powers](#) to respond “quickly and effectively” to the outbreak.

- The Prime Minister **announces** that the UK remained in the first 'containment' phase of the outbreak, but that extensive preparations are being made for a move to the 'delay' phase.
- The UK moves into the **delay phase** and the UK Chief Medical Officers raises the risk to the UK from 'moderate' to 'high'.
- In Wales, the Minister for Health and Social Services announces the **suspension of a number of NHS services** including non-urgent outpatient appointments and non-urgent surgical admissions and procedures.
- The UK Prime Minister **updates advice** that if anybody in a household has a new continuous cough or high temperature the whole household should self-isolate for 14 days.
- The **Health, Social Care and Sport Committee receive** a briefing from the Chief Medical Officer on the response to COVID-19 in Wales, and from the Minister for Health and Social Services on the emergency legislation. On the same day, **Regulations came into force** which provide for "the imposition of proportionate restrictions" on individuals where it was suspected that they may have coronavirus. Similar **regulations** were made in England in February.
- The UK Prime Minister **addresses the nation** – all people are now required to stay at home except for very limited purposes. Non-essential shops and community spaces are closed, and gatherings of more than two people in public are prohibited. These measures are enforceable by the police and other relevant authorities. The First Minister of Wales makes a **statement on the new measures**.
- The Welsh Government publishes **guidance for those who are identified as extremely vulnerable to the coronavirus**. This includes information on the delivery of medicine and food as well as what to do if you're living with somebody who is vulnerable.
- Following agreement by both Houses of Parliament the **Coronavirus Bill** receives Royal Assent.
- Cardiff and Vale University Health Board **announces that** the Principality Stadium in Cardiff will be set up as a temporary hospital to provide 2,000 extra beds to the NHS.

- The Minister for Health and Social Services **announces** a new coronavirus testing plan for Wales.

April 2020

- Following a rapid review of PPE across the UK, **new UK wide guidance** is published.
- The **stay at home regulations are revised in Wales** to clarify that people who leave their home with a reasonable excuse (such as for essential shopping, healthcare or work) cannot remain outside to do other things. New arrangements also allow people with certain health conditions or disabilities to leave home to exercise more than once a day. This is particularly aimed at helping families with children with autism and learning disabilities.
- Welsh Government publishes its **'framework for recovery'** from the coronavirus pandemic.
- The **Health, Social Care and Sport Committee** meets remotely to scrutinise the Welsh Government's response to coronavirus. The Health Minister answers questions on **personal protective equipment** (PPE), testing and an 'exit strategy' for lifting the current coronavirus restrictions.
- The **UK Prime Minister says** at the daily press conference that "we are past the peak of this disease".

May 2020

- **Lockdown is extended for a further three weeks in Wales** with some minor amendments to the restrictions: people may go out to exercise more than once a day but must stay local.
- In a **televised address** the UK Prime Minister outlines changes to lockdown restrictions in England and promotes a new 'stay alert' message. The 'stay at home' message remains in place in Wales, Scotland and Northern Ireland.
- The Welsh Government publishes its **testing strategy** - Test Trace Protect - to "enhance health surveillance" and "undertake effective and extensive contact tracing".

- The First Minister outlines the roadmap for easing the restrictions in Wales. It includes nine areas with four steps moving from the lockdown, to red, orange and green.
- The Minister for Health and Social Services announces that all care home residents and staff are able to access tests on the UK Government portal.
- The four UK Chief Medical Officers issue an update to coronavirus symptoms to include loss of smell or taste.
- People in Wales with symptoms of coronavirus should be able to request a home coronavirus test via an online booking service. This is part of a new, UK-wide system for ordering home testing kits.
- In Wales, following the three week review of the regulations, the First Minister announces that the ‘stay at home’ message was changing to ‘stay local’ from 1 June, and that two households can meet outdoors and social distancing and good hygiene practices should continue to be followed.

June 2020

- The Minister for Health and Social Services announces changes for people who are shielding from today, but are advised to do so at times that are less busy to reduce the risk of contact with others. All who are shielding “will receive a letter from the Chief Medical Officer for Wales before 15 June setting out the next steps”.
- With contact tracing being rolled out, anyone who tests positive for coronavirus will be contacted by a contact tracer and asked to provide details of everyone they have been in close contact with. Those close contacts will be contacted and asked to self-isolate for 14 days.
- The Health Protection (Coronavirus, International Travel) (Wales) Regulations 2020 come into force – residents and visitors entering the country from overseas must self-isolate for 14 days to prevent the further spread of coronavirus. This reflects a common position across the four UK nations.