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The COVID-19 pandemic in Wales: Public health governance, preparedness, and vulnerability

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Introduction

This report gives a brief overview of how the COVID-19 pandemic was managed from the perspective of public health in Wales. Discussing the public healthcare system, the operationalisation of vulnerability in various aspects of the pandemic policies, and the country's preparedness and follow-up strategies for COVID-19, the report focuses on institutional factors influencing public health responses, social precarity, and public health communication, as well as the impacts of COVID-19 on health care workers until September 2022. It offers lessons learnt at the end of each section.

The report is based on Welsh pandemic governance policy documents, academic literature, and public health expert interviews. The experts interviewed include (1) with public health decisionmakers, people who have implemented pandemic healthcare policies; and (2) healthcare workers who worked in clinical settings during the pandemic in Welsh hospitals. The interviews were conducted over Zoom or Microsoft Teams, the audio recordings were transcribed, and analysed thematically in NVIVO 12. The interviewees have provided informed consent and quotations of their input have been anonymised. Ethical approval has been provided by the Swansea University College of Science Ethics Board.

The report is part of the larger COVINFORM Deliverables "D5.7 Analysis: Public health responses and impact" and D5.5 Public health responses: baseline report" and connected with COVINFORM Deliverables 4.7, 6.7, and 7.7.

The healthcare system and pandemic preparedness in Wales

The basic model of the Welsh healthcare system can be characterized as the so-called Beveridge or national healthcare model, based on universal health care coverage for all citizens provided by the Government (Kulesher & Forrestal, 2014). This national healthcare model is funded through taxation with a small proportion raised through national insurance contributions, and the Government has ownership of most of the delivery of health services (ibid.). Since the devolution of Wales in 1999, the country is responsible for healthcare provision and the National Health Service (NHS Wales) takes responsibility for health services to the population through seven Local Health Boards supported by three specialist NHS trusts (Longley et al., 2012).

Healthcare is primarily provided through the publicly funded NHS Wales and added to by the private sector. Public Health Wales (PHW) is the national public health agency in Wales and is one of the public bodies that forms part of the Welsh NHS. One of its roles is to protect the public from infection and to provide advice on epidemiology (i.e. the incidence and prevalence of disease). Although operationally independent of the Welsh Government, it advises and acts at the Welsh Government's direction.

The Welsh pre-pandemic preparedness strategy is aligned to the overarching UK-wide strategy. The main Welsh document that resembled a pandemic response plan or strategy is the *Wales Framework for Managing Infectious Disease Emergencies 2005.* It set out national arrangements for managing major infectious disease emergencies, which included national coordination, operational responsibilities of NHS organisations and the role of partner agencies. Wales also had a more pandemic-specific response plan; the 2007 *Pandemic Influenza Guidance Planning* was established before the 2009 influenza pandemic. For emergencies in general, Wales had the *Pan-Wales Response Plan*, that entails the "command, control and co-ordination urgent response structure for national emergencies and includes activation levels and multi-agency responsibilities" (Welsh Government, 2021: p2). These plans were replaced by the UK-wide *Preparing for Pandemic Influenza: Guidance for Local Planners* issued in 2013, which "aimed at Local Resilience Fora, provides additional guidance and information to support the development of local level multi-agency plans" (p5). It worked in conjunction with the *UK Influenza Pandemic Preparedness Strategy 2011.*

COVID-19 pandemic governance

In planning for the COVID-19 pandemic, Wales was initially aligned with the UK-wide pandemic response and officials took seat in the COBR (Cabinet Office Briefing Rooms) meetings and was updated by the UK-wide Scientific Advisory Group for Emergencies (SAGE). SAGE is led by the UK government chief scientific adviser (GCSA), Sir Patrick Vallance, and the chief medical officer (CMO), Chris Whitty. SAGE is an ad hoc committee that brings together government scientists and officials with external experts.

On March 18, 2020, Wales initiated its own health protection regulations. In Wales, the Coronavirus Restrictions were approved by the Welsh Parliament on March 25th, giving Wales the power to manage the pandemic independently of the other British nations. Documents followed by the decision makers and authorities entailed assessment of the efficacy of the pandemic measures in place and need for adjustment. These were daily, weekly, and demand-based briefing and advice documents (Welsh Government, no date a) and impact assessment documents (Welsh Government, no date b). The collections that were not internal are mostly (still) available on the Welsh Government website. Later on in the pandemic, these documents were published with a lower frequency.

As addition to the UK-wide SAGE group, Wales created a Technical Advisory Cell (TAC) and a Technical Advisory Group (TAG) to support SAGE in advising the Welsh Government and Public Health Wales[1]. TAG – SAGE experts, alongside the Chief Scientific Adviser for Health (Rob Orford), Chief Medical Advisor (Frank Atherton) and Chief Nursing Officer (Jean White followed-up by Sue Tranka) met three times a week to discuss the progress of the pandemic. TAG-SAGE experts inform the ministers, which in turn present changes to the regulations to the Welsh Cabinet for consideration. The Cabinet makes the final decision which is communicated to the ministers.

The Technical Advisory Cell had multiple sub-devised Cells, including the 'Guidance Cell', 'Telephone Cell', and 'Enclosed Settings Cell'. These cells consisted of people who had been working in different parts of Public Health Wales. Interviewee "DM51" explained that they used to work in health protection (e.g. smoking cessation), but shifted to working fulltime supporting TAG, in which they were encouraged to use their expansive network and communication skills to advise organisations, such as care homes and community groups, about the adoption of newly rolled-out pandemic regulation from the Welsh Government. They describe how the public health response procedures changed from beginning of the pandemic until January 2022:

> *"That information [from the Welsh Government] would reach us was never at the pace at which it was televised or announced. So, you know, as it progressed, obviously, we're now in a place, which is very different to the first wave, where there is more tactical input, there's more scientific input from the bodies. And that that process is very, it's very clear now. Whereas in those early, you know, months – quarter, it was very much, you know, they've announced something: 'what does this mean? What is our public health response going to be to this?' Because we are only an advising organization. We don't create any clinical advice that's on behalf of the NHS or Welsh Government."* (Interviewee DM51)

[1] https://gov.wales/technical-advisory-cell/terms-reference

The collaborative process is between the Welsh Government and its scientific committees and leaders with Public Health Wales and other health institutions seemed to have improved markedly. During the early pandemic days, the interviewee mentioned that she and her colleagues needed to check the website *WalesOnline* for news from the Welsh Government that they hadn't received before it was televised. A BBC journalist interviewed for this project corroborated this as Welsh government staff would give them information just a couple of hours before the press conferences at the start of the pandemic.

LESSON:

Given the confusion with pandemic measures being published with speed as the highest priority, a lesson learned seems to have been the recognition that cross-organisational agreement on the measures is more important than the speed of the announcements of public health measures.

Preparedness for pandemic vaccination and vulnerable groups

In preparedness strategies in Wales, vaccination had not been considered in particularly thorough ways because they anticipated an Influenza pandemic. As Influenza vaccines are relatively easily adaptable, vaccines were considered to be more easily and more widely available in the preparedness plans than the COVID19 vaccines ended up being. Vaccination in the preparedness plans was thus not considered a special or particularly important pandemic measure. Since its inception in Winter 2020, the development of the vaccination strategy incorporated ideas around equity, given that it was particularly concerned with 'protecting the vulnerable' in society. A public health expert who has been in charge of the vaccination plan explained how the programme started:

> *"I went fully over to the vaccination program in July (2020). And then we basically got together and established a program board with all of the health boards on it. And with a stakeholder group with many of the third sector partners on it, representing groups that would be interested in the vaccinations. And also a kind of the lens of the third sector for homelessness, asylum seekers and refugees, people whose mother tongue was not English, people who had a learning disability, or any disability. So it was a very broad ranging stakeholder group. And it was mainly so we'd have the board meeting for the planning over the summer, and then we'd have a stakeholder group to tell them what we're planning, we would do tabletop exercises with some of the different scenarios depending on what vaccine we thought might come through first, the logistics around that we'd have a number of subgroups underneath."* (Interviewee DM53)

This interviewee and another vaccine strategist interviewed for COVINFORM explained that when the first dose of the vaccines had been administered to the wider population, it became more clear what social groups had been less inclined to become vaccinated. Building on this new knowledge, the vaccine equity programme expanded its reach into newly identified vulnerable social groups by adjusting the intensity of their efforts to address those groups.

LESSON:

The lesson learned was the benefits of considering a changing dimension of vulnerability during the pandemic and being prepared for an increase in the categories and varieties of vulnerable groups. As such, new social groups were identified as vulnerable. In response to this widening of vulnerable groups, further kinds of health protection and types of organising the vaccination for them were considered.

Operationalising vulnerability in public health crisis management during the pandemic

At the start of the pandemic, ideas around prioritisation of certain groups over others for care, treatment, and support took place along lines of 'lack'. Priorities were placed on people considered less capable of coping with illness, suffering, and considered less dependent from institutional support. Vulnerability was often used to indicate a gradient of such lack. The meaning and usage of the term 'vulnerability' was strongly related to the line of work of the interviewee. Their understanding of the concept reflects in the pandemic management decisions. Medical staff and public health officials who worked on applied decision-making processes tended to consider vulnerability in a more strictly clinical way in the context of the pandemic with age and pre-existing conditions being of highest concern. The Chief Nursing Officer for Wales since August 2020 placed vulnerability at the heart of the pandemic response in Wales in the policy development concerning COVID-19:

> *"We think of people and then we think pathways don't really think oh, yeah, the cardiovascular groups, and then diabetic people. And we don't really stratify people in other groups. But I think in the pandemic, we started to stratify people for vulnerability, what were their social vulnerabilities? What were their mental health vulnerabilities? What were the physical vulnerabilities? And, and the policy started to be developed in that manner, which was the first time I've seen that sort of emergence of thinking, which is quite a maturation in a system, which I think what I assumed was mature in the sort of national scale thinking before, this was a different type of idea. And what it showed us in the population is that those with social deprivation, those that have the social determinants, that impact with social terms are not as positive and will impact health, people have far more vulnerabilities and those vulnerabilities are not one, they will come in a mass. So if you're living in social deprivation, you know, your education abilities, or will be impacted your ability to have good social relationships and a stable home is impacted."* (Chief Nursing Officer for Wales)

Her account suggests a strong social aspect in developing pandemic measures to address social difference and mitigate social impact of COVID-19. However, according to Interviewee DM54 with public health expertise this social aspect and the attention to mental health, social deprivation, and education level amongst other social determinants of health had been more or less lost in the implementation of pandemic health policies. They stated that the actual term 'vulnerability' was often not part of their everyday vocabulary in deciding where to intensify testing efforts.

"Purely because when the vaccines did start to come out we found there is a bit more hesitation. (…) it wouldn't be a word that we've use 'vulnerability'; it's all about the data and where the cases are. So then might be certain areas at time that would have been more at risk. So again, it's that language, I think 'being more at risk to COVID' that had to have additional measures. So for example, at the time, Llanelli town was a hotspot in terms of the amount of cases that were coming through there. So it was a very much – that was a high risk area. So we had to target more of the workforce in terms of sending testing the mobile testing unit out there. So yeah, again, you know, in terms of the concept of vulnerability in a health protection world – it would just be, the language would be about risks in relation to COVID and the setting." (Interviewee DM54)

Illustrating the lack of prioritisation of the human aspect in the pandemic policies, for this interviewee and their public health teams, pandemic management seemed to be more black and white: the presence of absence of COVID-19 cases, which was then associated territorially with a higher (or lower) risk of requiring more resources, including tests and healthcare workers.

Similar to how vulnerability was considered in the broader pandemic measure development, also in public health spheres vulnerability seemed to have been a concept with which pandemic policy could be social policy in nature as well. However, in the implementation and operationalization the concept seemed to have diminished in its capacity to guide the pandemic response more holistically. Instead, it gave way to more measurable concepts such as 'risk', which affirm public health science interpretations of vulnerability as weakness and lack through the application of higher risk scores for higher levels of vulnerability.

LESSON:

One lesson that can be learned from the employment of 'vulnerability' in policy entails the necessity of having expertise in the social dimensions of illness, health, and living in a society. In particular at lower operational levels such expertise is key to hold onto social sensitivities in the pandemic response, not just at the higher policy level. Addressing the capacity of vulnerability to include many aspects of life in pandemic times that are difficult to measure, there is clearly a need for accepting qualitative criteria of measuring impact of the pandemic in addition to quantitative ones.

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