Llywodraeth Cymru
Welsh Government

MEETING

COVID-19 Moral and Ethical Advisory Group Wales meeting: 15 January 2021

Minutes of the COVID-19 Moral and Ethical Advisory Group Wales meeting held on 15 January 2021.

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Actions

Actions

Action	Responsible
1. Meeting dates to be reconsidered.	HP/KF/LD
2. SHAW Terms of Reference to be shared with group.	CR
3. Comments in side bar to be shared with TRD and KH.	Secretariat

Attendees

Heather Payne (Chair), Aled Roberts, Kevin Francis, Alison Parken, Rhian Davies, Viv Harpwood, Carol Wardman, Kathy Riddick, Aled Edwards, Ben Thomas, Julian Raffay, Paula Hopes, Helena Herklots, Tirion Rees Davies, Katy Hossack, Idris Baker, Martyn Jones, Rhian Davies

Welcome, apologies and introductions

The Chair explained the need to change the day that meetings were held, with Friday offering diary availability. On reflection, it was realised that this interferes

with Holy days and apologised were made. Meeting dates will be reconsidered and colleagues consulted to ensure that we are not excluding anybody.

Julian Raffay was welcomed to the group. Julian has taken over from John Wilkes as Director of Chaplaincy Study at Saint Cadarns. Previously worked in a Parish as a Vicar, immediately before that as a Research Chaplain. Spent most of life working in Mental Health Chaplaincy. Very passionate about Chaplaincy but also coproduction, which is what his Doctorate was based on.

Together with Kathy Riddick, Idris Baker and Heather Payne, Julian is a member of the Spiritual Health and Wellbeing Group (SHAW) which is chaired by Professor Linda Ross based at the University of South Wales. This is a Wales wide organisation advisory Group which reports to the Chief Nursing Officer because of the evidence importance of taking a spiritualist approach to people's wellbeing in healthcare, this can be faith based or nonfaith based. It is important to understand the delivery of Chaplaincy services across the NHS in Wales.

Kathy is a long standing valued member of this group and has offered to be the formal link between CMEAG Wales and SHAW. SHAW meet once every three months and therefore CMEAG issues which can be shared to the wider group will be communicated on a quarterly basis.

Kathy explained that SHAW spent a lot of time on how to define spirituality in terms of healthcare and what is meant by spiritual care. This is included in the Terms of Reference, which will be shared with CMEAG to ensure a common understanding.

Previous minutes

The Chair asked group members to provide any comments/amendments regarding the note of the last meeting to the Secretariat.

Apologies made to Viv Harpwood who was missed from the attendee list and credit for the anti-vaccination presentation.

Previous actions

Agreed to carry over to next meeting.

QCOVID risk calculation tools

Katy Hossack and Tirion Rees-Davies joined the meeting from the Welsh Government Shielding Team who are responsible for thinking about the needs of the clinically extremely vulnerable people within the population. These people are identified on the shielding patient list.

At the start of the pandemic the University of Oxford researched which factors make people more vulnerable to short term poor outcomes from Covid. Initial use of the algorithm would be to identify any clinically extremely vulnerable people that have not already been captured by the shielding list process. The algorithm allows us to look at a combination of factors, which our colleagues in England are potentially going to use to identify additional clinically extremely vulnerable people who will then have group 4 priority access to the vaccine. This is the starting point and we are looking for general guidance and feedback from the group. The group were invited to share their views.

Comments:

- Explain more about typology 'it could be used in a number of ways at population level as a tool to support clinicians and the public facing'.
- SPL - it would be useful to unpack the connection between the current list and the proposed use of the app

- Are we primarily looking at shielding or vaccines?
- Referring to an earlier conversation before Christmas, at that point, 68% of those who have died from Covid in Wales had a disability. Where are those with a disability or learning disability in the algorithm?
- How are you accounting for the impact of social economic factors? This does seem be part of vulnerability in terms of severe illness and death. How are you accounting for the medical and social factors interactions?
- It is apparent that people of faith communities are being persuaded to not partake in the vaccination programme.
- Issue around the balance of keeping places of Worship open and thereby having access to people who would need advice and help.
- How can we begin to establish algorithms that have been pertinent and up to date with communities and individuals who really need out balanced thoughts?
- A medical model is being applied to the algorithm but the main problem is not always medical, it is social and environmental.
- Outcomes are clinically worse for those with obesity. People need information on how their BMI will affect their outcome so that they can be more vigilant with prevention.
- Anti-vaxxers are creating a public safety moral dilemma. Public health workers are being harangued and need support.
- Places of worship do not have good air cleansing machines fitted. Health warning is needed to help the public make an informed decision.
- Masks should be worn all the time outside the home to give a clear message.
- Funeral Directors are at very high risk but are not on the priority list. They are a skilled workforce and not replaceable.
- Do we have feedback from Welsh clinicians over use of tool? Is it user friendly? Are there any gaps if we were to adopt it?
- **Coronavirus: ethical values and principles for healthcare delivery framework**. This initial advice and paper was based on clinical ethics but now we have clear factors of social justice involved. It is advisable to include

theories of social justice and essential to develop a set of clear governing principles.

- Anti-vaxxers - imperfect prioritisation will always win over a perfect prioritisation that happens slowly.
- Thought should be given to how the principles are expressed in the paper. Treatment is normally to benefit an individual whereas treatment in the form of a vaccine is for the benefit of others. We need to think about how we present this balance against the principles.
- GPs in England have challenged the JCVI with the marked difference in different geographic areas where people get to old age. If the vaccination is age based you will find the wealthy communities have a much higher rate of vaccination which protects everyone in that community compared to a neighbouring community where fewer people make it to an older age. These communities are already at risk for the reasons we have looked at and getting less protection.
- Impairment and health conditions can be multiplied by their housing situation, interactions with care and service providers and employment. A high percentage of those with health conditions are in low paid employment and key workers. It is important that all factors are taken into account.
- How are individuals informed of their risk level and how will they be supported? Can this information be used to tackle the wider inequalities in society? Is there potential that this information could be used to cause harm, in a discriminatory way with issues like insurance or future employment.
- The wider community are not represented in the modelling of risk or understood. There is a systematic inequality for the invisible population who are underserved.
- Do we need this algorithm? What is it going to do that we are not able to do at the moment and why do we need it?
- We need to question what we mean by public use, this tool would not be used by anyone who cannot access the internet or those who are not confident to use the tool. If publically available, what is the support around that? Where do you go for support on learning you are high risk?

- Data is too expensive for many people. The people we are trying to reach will probably not have access to the NHS tool.
- Who can wait? People living comfortably in nice housing can wait. Young people have to go out to work, single parents are dying and leaving orphan children. We are stacking up huge problems for society in the future.
- The press reporting on roll-out problems are fuelling the anti-vaxxers, better discussions are needed with the mainstream media to deliver messages about who is at risk and that the vaccine will protect them.
- Data, we need to challenge the telephone companies who have not given free data to everybody. This needs to be tackled on a central government level.
- Schools, we need to be rolling out computers and to scrap the agencies providing school meals. Those receiving food vouchers are those going out to work and at risk.
- It is very important that we get this right in Wales as it will feed into other things such as prioritisation for vaccination.
- We should be vaccinating carers at the same time as the vulnerable person they support.
- We need a good set of criteria on which to base decisions. The paper refers to the individual risk of short term severe outcome but we need to consider long term consequences of COVID as some have been severely disabled by it.
- Katy and Tirion thanked the group for the discussions and key points raised which they we share with colleagues in England and the vaccination team.
- The Chair asked group members to provide any detailed comments or further information to the Secretariat. A summary of these discussions will be prepared and put out as a paper.

Vaccination board

We now have a vaccination board in Wales chaired by Dr Richardson and Claire

Rowlands. The vaccination subgroup have asked for a CMEAG representative to sit on their group and on receipt of the finer detail we will ask for expressions of interest.

Vaccination and mental capacity

The group were asked to consider the draft paper prior to the meeting and invited to share their views.

National Mental Capacity Forum ran a rapid response webinar aimed at addressing these questions.

The best interest decision has to be taken in the interest of that person and every effort has to be made to involve them in the decision. Their capacity is judged for that decision at that time, it is not an absolute.

It is not the view of the family that is overriding, it is how the family feel the person would have felt if there was a lasting power of eternity or not.

Restraint – how is this defined

The paper should include the need for information to be given beforehand to minimise the risk of resistance. Many tools are available to help understanding. Topical anaesthetic gel could be used for hypersensitive skin.

Question at end of paper is punitive towards the person who has not been vaccinated because of the fundamental processes prior to vaccination.

It has not been recognised that you could be vaccinated but still be a virus carrier.

Population screening/vaccine programme was not envisaged when the MCA was created. Speed is of the essence, we are worrying about discriminating against people where a very quick best interest decision cannot be made, these challenges need to be recognised. Confusions around understanding the Mental Capacity Act and its application in healthcare. It is difficult to develop a system to support this decision making and roll out the vaccine on the scale that we are.

Ministerial Advisory Group on learning disability has an abundance of expertise and understanding of the Mental Capacity Act and can help inform a guidance document.

Human Rights and under the Mental Health Act, negligence is an issue, restraint needs to be defensible and proportionate.

Paula will share a document that she is currently working on with the health board regarding reasonable adjustments to prepare people for a least restrictive approach where the multidisciplinary team have agreed that it is in the person's best interest to have the vaccine and the measures to take to avoid physically holding them.

The Chair asked group members to provide any detailed comments or further information to the Secretariat.

Next meeting

29 January 2021