A Review of the Health & Social Services Group Response Structure to COVID-19

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Portfolio:	Health and Social Services Group
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SECTION 1 – REPORT STRUCTURE

1. Background

1.1 In January 2020 the World Health Organization (WHO) referred to Covid-19 as a public health emergency of international concern and subsequently on 11th March 2020 declared Covid-19 a pandemic.

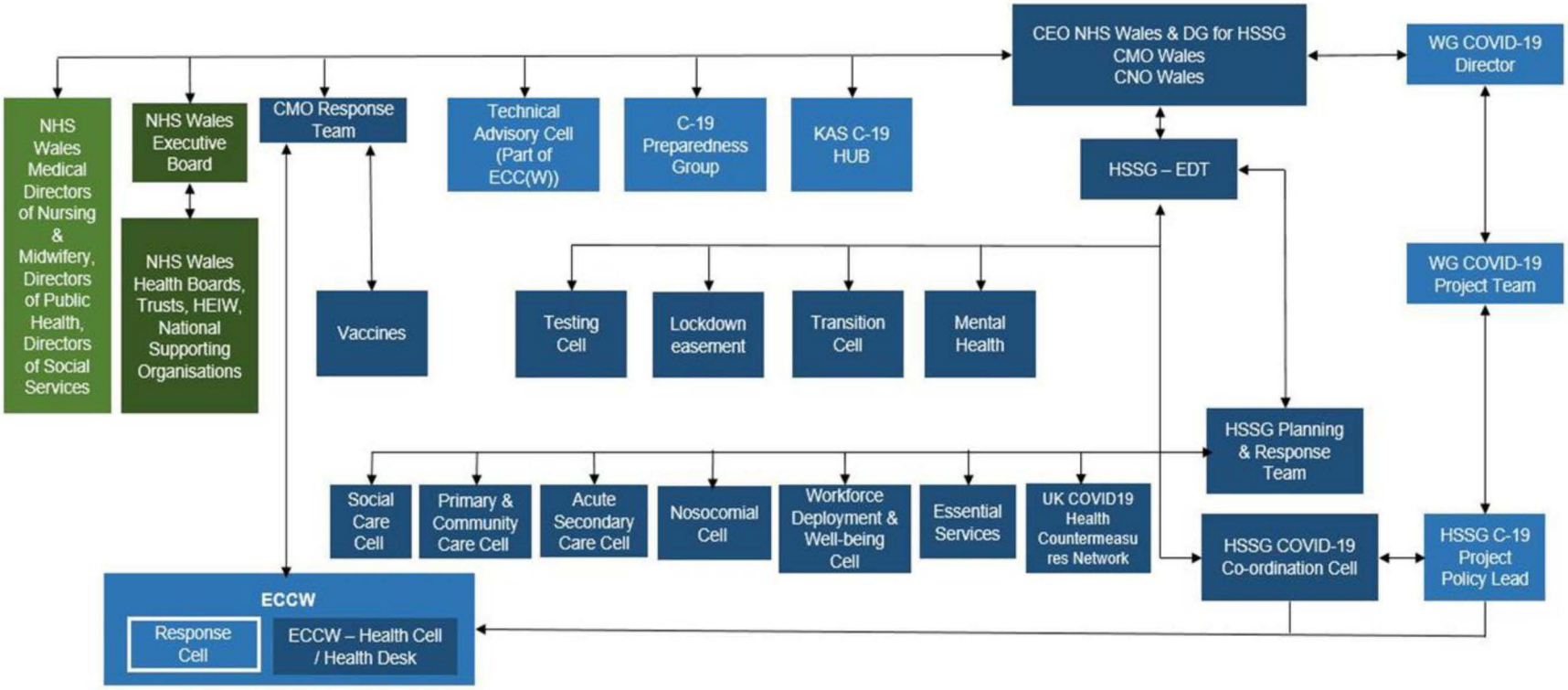
1.2 Welsh Government established its Emergency Co-ordination Centre (Wales) (ECCW) and Health & Social Services Group (H&SSG) set up its H&SSG Desk as part of ECCW to provide a contingency contact for healthcare services, partner agencies and Local Resilience Fora's (LRFs). (The Group's response is set out in the "H&SSG Arrangements for Responding to Emergencies" document).

1.3 The Chief Medical Officer led the public health response and H&SSG quickly set up a COVID-19 Planning and Response structure to co-ordinate NHS and social services activities. As we moved through the first phase of the pandemic, a number of groups, sub groups and cells were established to support our response.

1.4 At the UK level, the Scientific Advisory Group for Emergencies (SAGE) was convened and Welsh Government stood up its Technical Advice Cell (TAC) to consider the SAGE advice in the context of what was happening in Wales

1.5 The H&SSG Covid-19 Response Structure that has emerged is set out below:

HSSG Covid-19 Response Structure



2. Scope of the Review

2.1 The scope of this review is to identify learning from January to September 2020 in order to consider how we might approach further phases of Covid-19 (including concurrence with other incidents through winter). This learning will be used to strengthen the H&SSG's Covid response in the immediate term, as well as informing emergency planning arrangements more generally for the future.

2.2 The following areas were considered out of scope for this review:

- Evaluating policy responses which were not formally owned and delivered by H&SSG;
- Evaluating H&SSG staff satisfaction with their role in the Covid-19 response;
- Evaluating the quality of expert scientific and medical advice; and
- Assessing individual responses by National Health Service (NHS) organisations or social services.

3. Participants in the review

3.1 A survey was circulated to key individuals who were identified as directly involved in the Covid-19 response (Annex A) and views were also sought from all H&SSG staff. Seventeen responses were received from key individuals, sub groups and cells. All of the responses can be viewed in the document below but which are anonymised:

H&SSG Review Survey - All Response

4. Overall Conclusion

4.1 The responses highlighted evidence of good practice including:

- Effective partnership working across Welsh Government and NHS partners;
- Significant use of technology - remote working for staff enabled an efficient response to emerging issues and digital platforms enhanced patient experience.
- Speedy initial response that has ensured that there are mechanisms/ structures now in place.

4.2 All responses suggested areas for improvement, some of which are focussed on operational issues which are best dealt with by the policy or response leads concerned. The Executive Director Team and those with senior roles in managing the Covid response are advised to read the responses where appropriate to their Covid-19 response accountabilities.

SECTION 2 – KEY THEMES AND SUGGESTIONS FOR IMPROVEMENT

Key Themes

Whilst multiple examples of good practice are noted in the attached returns, this report will focus specifically on areas requiring strengthening. The following key themes and findings have been drawn out from the responses that were received and have been grouped under the following headings:

- **Incident response**
- **Policy development and delivery**
- **Communications**
- **Governance and accountability**
- **People, skills and wellbeing**
- **Positive outcomes**

1. Incident Response

Structures, roles and responsibilities

1.1 The responses suggested that guidance and protocols evolved continually creating difficulty for staff to keep up with changes. Initial co-ordination between cells took some time to establish and understand which members of staff were attached to which cells and internal mailbox arrangements and confusion between the roles and responsibilities between some of the cells. This resulted in duplication particularly when sit-reps were being developed, which made for an ineffective reporting rhythm.

1.2 The H&SSG whole system structure did not appear to be visible enough. Cross cutting discussions meant topics were often bounced between sub-groups. The principle of discrete 'Cells' should have resulted in clear lines of accountability and collaboration with the service. In reality the scope of many cells was not clearly defined, which at times created confusion and duplication. It was unclear to many as to how the cells integrated into the overall planning and response structure.

1.3 Whilst H&SSG was very responsive to the communications team requirements and met tight deadlines, it felt like the rest of the organisation were slower to respond and recognise the severity of the situation.

1.4 There were challenges with multiple reporting lines to Ministers via the NHS performance team, Public Health Team, Knowledge Analytical Service (KAS) and Public Health Wales (PHW). KAS were not sufficiently involved early on in the process for sit-reps or surveillance data to influence or agree definitions. Responsibilities within KAS between health statistics and the Covid Hub were not always clear cut.

1.5 At the very early stages (March) Social Services Division (SSID) were under significant pressure from local authorities and providers to source and distribute PPE. That demand seemed to pre-empt PPE guidance on what should be provided and when it

should be used. It was sometimes difficult to engage with health focussed partners on the needs of the sector.

Suggestions for improvement:

- Confirm the overall H&SSG Planning and Response structure for winter and the role of the Executive Director Team (EDT) in providing overall co-ordination and leadership (page 3).
- Clarity on the key roles and delegated responsibilities within the structure and ensure key areas are sufficiently resourced from the outset, including the relationship between internal facing and external facing mechanisms.
- Look for ways to improve co-ordination between the elements that comprised our whole system response eg linking officials and reporting procedures.
- Ensure that members of staff attached to sub groups or cells are known and mailbox arrangements internally within Welsh Government are developed to maximise the efficiency of response.

H&SSG response arrangements

1.6 In March, the H&SSG COVID Preparedness and Response Framework was issued to key stakeholders and set out the structure put in place to co-ordinate the health and social care sector response to COVID-19 and the key national decisions taken to support that response. Subsequently an Addendum to the Framework was developed to reflect developments but was not issued as the COVID wave had passed through.

Suggestions for improvement:

- Review the H&SSG Preparedness & Response Framework before winter to confirm overall structure and key roles and responsibilities.

The Health & Social Services Group Desk

1.7 The Group's initial response to an emergency is set out in the H&SSG "Arrangements for Responding to Emergencies" which was not activated as expected. The Deputy Director responsible for oversight of the H&SSG Desk in ECCW was moved to another priority role at the beginning of the pandemic and although temporary posts were created, the overall approach meant the Desk did not really have senior input/ support to enable the redeployment of staff and to agree a battle rhythm.

1.8 Staff were not released from existing posts within the timescales required which significantly impacted on the ability to move to extended hours sooner and to train people properly. Once the full complement of staff was in place, resources for the Desk were adequate. However, this became an issue towards the end of phase one response, when a return to Business As Usual (BAU) roles left the team without a coordinator for a time, which is less than acceptable in terms of staff welfare / leadership and governance.

Suggestions for improvement:

- Review the H&SSG Desk role and its links to other parts of the H&SSG response structure and ECCW before winter. Contact details need to be reviewed and a battle rhythm agreed. (NB. the role of ECCW operations is currently subject to a separate review.)
- Review the H&SSG accountability for mobilising the H&SSG Desk into ECCW and its staffing so as to have the right level and mix of trained staff.

Data/ Information management

1.9 Data availability and reporting took some time to be established. Hospital transmission data only being made available to the NHS in late July/ early August, which was then cascaded to the public via the PHW Coronavirus Data Dashboard. Primary care escalation was vital in monitoring system health and initially was the only regular data source. The Covid Data Hub however proved an excellent achievement.

1.10 Workforce data brought challenges as it was unknown which nursing and midwifery registrants on the Nursing and Midwifery Council (NMC) temporary register had been deployed and to where. There were challenges with the lack of one maternity data system to provide timely intelligence.

1.11 There were issues that arose in mortality surveillance that are well documented and could have been avoided via greater roles and responsibilities and adherence to some principles around management of administrative data. There was a lack of clarity on who was reviewing the mortality data and ensuring Local Health Boards (LHBs) were submitting surveillance data.

1.12 There was a multitude of dashboards being prepared for different purposes sometimes with similar but slightly different data flows. In terms of PHW, this appeared to be done without any regard to what else was happening in the system leading to duplication of similar outputs between PHW and Welsh Government (WG) and creating confusion in the media and to the public.

1.13 Where data requirements for the UK Government (UKG) were different to those being used within Wales (e.g. different measure or different timing of the data) it was difficult to know which should take priority, as many issues could be seen as political (e.g. UK comparability was important but as was comparable trend data for Wales).

Suggestions for improvement:

- Review data and information management processes to clarify what data is needed and why and who is best placed to provide it and in what form. This could be achieved through an information management group involving all the key players; KAS, Digital Cell, NHS Wales Informatics Service (NWIS), PHW surveillance and possibly Technical Advisory Cell (TAC).
- Develop guidance for completion of sit-reps containing quantitative data and to the data itself to see whether there is scope for improvements.
- Ensure lessons learnt from mortality surveillance review are captured for future incidents.
- Ensure sufficient availability of data is available within WG to support developing policies, particularly in epidemiology, health statistics and infection prevention and control.

Decision making influences

1.14 Emerging scientific evidence and four nation engagement was initially good in informing Welsh decisions. There were challenges with this approach later and a retreat to single nation perspective from England and little connection to NHS England. The emergence of the TAC in influencing decision making was an important new development.

1.15 The initial response did not focus on maintaining non Covid-19 essential services and potential consequential indirect harm. This was realised within weeks and a framework developed but the work was then on the back foot and created difficulty in reinstating services, as staff were redeployed for Covid-19 work. Further work is needed to agree key metrics and overall assurance framework to track impact on outcomes.

Suggestions for improvement:

- A central weekly grid of planned activity should be co-ordinated by government business and updated daily to share across the group reflecting all pandemic-related activity.
- The remit of the TAC may need to be considered and its role in the policy development and decision making processes clarified together with its relationship with other influencers such as KAS, Digital, PHW, Scientific Pandemic Influenza Group (SPIG) and Sage.

Staff resource

1.16 Many suggested that there are now more challenges due to juggling Covid-19 roles and responsibilities as well as trying to do the 'day job' with insufficient resources. The option to stop doing elements of the day job isn't easily achieved and stakeholder engagement is consequentially more challenging.

1.17 The initial response was resourced by small, dedicated teams that quickly became overwhelmed. Lack of resilience for staff dealing directly with the Covid-19 response at an early stage was an issue, particularly resources in Health Protection and the Health Emergency Planning Unit (HEPU). Public Health Division staffing of the ECCW Health Desk stalled and fell to HEPU which created a major resource issue. The swift movement of staff to create the KAS Covid Hub was only possible due to de-prioritisation of a range of other analytical work and the TAC experienced performance issues due to a gap in the skills and expertise that the Cell required. The Planning Team managed a Covid mailbox for external offers of support, which became unmanageable over time.

1.18 SSID lacked sufficient resource and staff movement to priority areas left core work on hold, which was challenging. Some areas were continuing to undertake BAU work, whilst others were trying to keep heads above water. There was some frustration where line managers wanted staff to return to their posts to go back to BAU.

Suggestions for improvement:

- Earlier senior recognition to enable staff resources to be identified and ready to release and redeploy earlier with account taken of the impact on BAU.
- Establish a cross H&SSG Emergency Planning Group to secure engagement of all Directorates in emergency planning, including consideration of staffing to support the response to national risks.
- Consider future resilience of teams to deliver reactionary and BAU activities by ensuring the necessary mix of skills and expertise and a retention of key staff to undertake/maintain levels of delivery.
- Consider adopting a fast track system to move people across groups and consider the uptake of external secondments in an emergency situation.

Partnership working

1.19 There was evidence of strong partnership working between all agencies and through the planning and response structures that emerged, particularly through the external facing Planning & Response arrangements. For example, the Health Countermeasures Group came together early February and worked through to June and brought together a team from Shared Services, Pharmacy, Social Services, PHW, the military and WG to manage PPE sourcing and distribution.

1.20 Other groups and cells were formed and worked in partnership under the auspices of the Planning and Response Group. These groups achieved an amazing amount very quickly, which included clinicians, professional advisers, policy officials and strategic representatives of healthcare organisations.

1.21 There were examples of good partnership working across the UK Health Departments but as our responses diverged and pressure mounted on key resources, this partnership became fragmented.

Suggestions for improvement:

- Clarify with Department for Health and Social Care (DHSC) its structure for response co-ordination and working with health departments in the Devolved Administrations (DAs) so as to avoid surprise announcements.

New ways of working

1.22 The Digital Cell was established in late March, resulting in all LHBs/Trusts collaborating on an approach and requirements to mobilise NHS Wales for remote working, Virtual Private Networks (VPNs), laptops, data centre hardware, enhancements to current technology to support testing and outpatient needs. NHS Wales video consultation capability quickly deployed to primary care.

1.23 External services have had to introduce new ways of working through the use of technology, providing an opportunity to review and assess current arrangements. However, in the very early phase it was difficult to quantify the remote working capability across NHS Wales organisations and a data collection exercise to identify current-state was difficult to maintain throughout NHS Wales. There was a lack of a joined-up approach to multi-agency data work. The ability to share data more effectively needs to remain a priority to ensure it is captured accurately and safely.

Suggestions for improvement:

- Need to maintain focus on the 4 harms and ensure action is effectively prioritised across each as far as it possible by having key metrics in place, nationally and locally to track delivery and gaps in line with the essential services framework and NHS operating framework more generally.
- Ensure that digital is plugged-in to the broader conversations.

2. Policy Development and Delivery

Developing new policy

2.1 The development of new policies was challenging and emerged at pace. Significant unprecedented offers of help for PPE and equipment from suppliers became quickly

difficult to manage. Whilst NHS Wales Shared Services Partnership (NWSSP), Life Sciences Hub, Business Wales and PHW colleagues all developed their own processes for managing offers it was critical to build relationships with those involved to handle complaints from companies or duplicate offers.

Communicating new policies

2.2 There was often confusion on was leading on what in the main WG Twitter page and the H&SS Twitter page. It was difficult for the Web Team to keep up with the frequent policy changes with published pages. It was suggested that the protocol with PHW on communication has become blurred over time.

Suggestions for improvement:

- Every web page should be 'owned' by a policy official to advise on updates required and establish clear guidelines with the corporate digital team.
- Consider a central weekly grid of planned activity, co-ordinated by government business with daily updates, reflecting all pandemic-related activity.
- Revisit the protocol with PHW and clarify the WG and PHW communications role.
- Early warning of policies to enable effective communication, including easy read versions would be helpful.

Data/ information management

2.3 More assurance is needed around systems and processes with shared services "Covid Hub Wales" to provide accurate data on how the process works. Many organisations are recruited locally and the information is not captured within "Hub".

2.4 The auto-delete policy in WG could mean some crucial log data may be lost due to insufficient support available for logging and establishment of systems.

Suggestions for improvement:

- Consider the sharing of logs for a 'once for Wales' approach, across the WG and the NHS to prevent duplication and wasting of time and resources to support the current systems.
- Establish a "once for Wales "process and a system for all response staff data to be accurately captured, to help with the potentially movement of staff to support care settings or sectors more in need. Review if "Covid Hub Cymru" is capable as this system moving forward.

Socio-economic impact

2.5 It is important to ensure that the learning disability population and their families/ carers are taken into account when developing Covid-19 policies.

Suggestions for improvement:

- Consider the socio-economic impact when developing Covid-19 policies.

3. Communications and Engagement

Communications with central government and devolved administrations

3.1 Overall responses suggested that engagement with the UK Government and other DAs was unclear and there were challenges in many cases. It was suggested that initially

when DHSC were leading for UKG, the relationship was good and there was regular two way dialogue, which fell away as the Cabinet Office took over the lead. The WG were regularly unsighted on UKG plans for communication campaigns and announcements. DA engagement very much depended on personalities and a willingness to share. It appeared that there was lack of coordination between Cabinet Office and DHSC.

3.2 KAS reported that for Cabinet Office reporting and weekly catch ups with key contacts at Cabinet Office was valuable for understanding priorities. In future, complications with the Joint Biosecurity Centre could arise and so roles and data flows will need to be clearer. Issues arose in cross-UK discussions due to lack of consistent definitions and lack of transparency for the definitions being used across the UK.

3.3 Communication across the 4 nations was varied with problems cited in respect of UK government and SAGE access/advice/data which could in part be attributed to political connotations and Wales 'being a small fish in a larger pond' requesting additional output.

Suggestions for improvement:

- Request regular touchpoints with DHSC and other DAs.

Internal communications and engagement

3.4 It was suggested that the role of ECCW was generally unclear and specifically the ECCW Press Desk and how it linked with the H&SSG communications and press office.

3.5 Ministerial contact was good with direct lines of control for Ministers, providing a clear steer on engagement with the UKG on data. Whilst there was co-operation across H&SSG, this varied with other WG departments generally. Initially emails within H&SSG were too slow to be dealt with, which is assumed due to the lack of staff in appropriate roles and lack of internal plans and structures in place at that time.

3.6 Bird tables and communication between ECCW Health Desk and the main ECCW appeared to work well and responses from colleagues across the organisation were helpful in providing responses.

Suggestions for improvement:

- More initial H&SSG internal communication to all staff levels about the response model - who is doing what etc. perhaps a central mailbox to answer any internal queries – point people in the right direction.
- Seek clarity on work of ECCW and the press desk.

External communications and engagement

3.7 There was good evidence of strong communication and engagement with external stakeholders. However, the lack of IT infrastructure in some health boards created barriers in the sharing of information. ECCW Health Desk and across the H&SSG experienced difficulties in obtaining answers to urgent queries from PHW and in establishing who best to approach.

3.8 There was a lack of dedicated communications budget and procurement hindering the ability to react quickly in the early stages and to support the UKG campaign, creating

problems at the peak of the pandemic in meeting very tight timescales, securing additional budget and undertaking a retrospective procurement at the same time.

3.9 There was a lack of understanding of the roles and actions being taken by some of the various emergency structures Local Resilience Fora, Strategic Co-ordination Groups etc. and how these related to other Health and Social care mechanisms e.g. Regional Partnership Boards.

3.10 Stakeholder engagement was often fragmented. Response areas provided engagement but stakeholders also dealt with policy leads. Responses to the public was not sufficiently resourced putting pressure on staff to deal with many queries. Third sector engagement was difficult to begin with but improved over time.

Suggestions for improvement:

- A ring-fenced budget identified and emergency procurement processes / contracts in place for future emergency planning, public information campaigns.
- Additional media training for H&SSG members supported by a list of NHS and academia to avoid the same people 'burning out'.
- Clear messaging regarding the roles of PHW, WG, and health boards' roles at the start of any response.
- Improved health board infrastructure that will link with Local Authority (LA) systems.
- Communication & engagement with wider health partners should be agreed through an H&SSG battle rhythm.

Handling of correspondence from the public

3.11 There was confusion by the WG First Point of Contact about where to direct public enquiries. Significant amounts were routed through the ECCW H&SSG Desk, due to lack of understanding of its role. Enquires continued to be routed through the desk, even after clarification, resulting in significant amounts of queries still remaining outstanding.

3.12 Other departments experienced similar issues. Most thought that the handling of correspondence from the public had been very poor, due to the significant volume of correspondence and limited resources to enable the WG to deal with it in a timely manner, risking reputational damage to the Welsh Government.

Suggestions for improvement:

- Additional resources for the Government Business team.
- Establishment of a dedicated team for answering public enquiries.
- Consider establishing stakeholder group.

Keeping on track

3.13 Co-ordination of communications became an issue as more people were involved and quick decisions were required. This meant that communication teams were not always sighted on published or public material. PHW took many days to turn requests in some cases, whilst the expectation was often a few hours/ minutes by WG. This lead to the same queries being re-directed whilst the media were awaiting a response.

3.14 Initially, the volume of emails was overwhelming which caused duplication with responses. There was no easy way of finding out who was leading on what with so many people stepping out of their normal roles and everything moved so fast.

Suggestions for improvement:

- Consider a clearer process for answering media and Ministerial requests across HSSG, KAS, NWIS and PHW.
- Need to have a clearer understanding of role of PHW in providing public information and for them to agree this role.

4. Governance and Accountability

Roles and responsibilities

4.1 There were challenges experienced by sub groups as to who was making decisions, normally covered at Deputy Director level. There was evidence of scope creep and the spontaneous creation of other 'groups' which at times appeared to be operating without a clear mandate. On occasions, there was lack of clarity on which areas were being led by WG or PHW. There was a feeling that work streams evolved separately in response to the pressure of work and various reporting mechanisms just recording activity and outputs. There appeared to be a lack of mechanism providing oversight and leadership for the organisation's strategy in dealing with the pandemic, making it hard to take ownership and make decisions for some cross cutting issues.

4.2 At times SSID felt that there had been little interface between policy leads and scientists and researchers. Developing an interface would have been beneficial in terms of accessing support, advice and evidence to inform the work-streams.

4.3 Significant time went into the star-chamber process and it often felt like lead officials and lead Ministers were sometimes kept at arms-length from important decisions. The processes led to lengthy delays in decisions and implementation which was extremely difficult to defend with people on the ground.

4.4 Digital Cell had sufficient support from across NHS Wales to provide leadership, accountability and decision making. Development of new transitioning governance arrangements developed closely with this Cell.

Suggestions for improvement:

- Clear decision making parameters for sub-groups and roles and responsibilities.
- Provide training to the Civil Service on information management and recording in exceptional circumstances such as major incident/ event.
- Ensure greater clarity of roles between WG and PHW.
- The Hine Report following Swine Flu recommended one authoritative source for scientific advice but for COVID we relied on sources from SAGE, unofficial SAGE, SPIG and TAC, which needs to be considered.
- Ensure Nursing Officer inclusion from an early stage in social care planning and response.
- The establishment of the NHS Executive needs to be urgently progressed- experience of the last 5 months has shown the need for such an organisation to lead/support the system.

- Consider how some areas cross across teams (e.g. face coverings although still linking to respective policy area e.g. transport, sport).

5. People, Skills and Wellbeing

Staff flexibility

5.1 Staff members reacted flexibly to the fast changing pace and movement into priority areas, which was a fast learning curve and welcomed the opportunity of variety and to be part of the 'fight against the virus'. Most staff worked exceptionally hard, working shifts, long hours and weekends, over and above of what would normally be expected, often based on good will. Whilst the fragility of staffing structures became apparent, individuals coped differently to manage the stresses of this and many were supported by their teams. In the short term this provided opportunities and empowerment, which is however, unsustainable in the long term.

5.2 Rapid response resulted in staff needing to adapt quickly to new ways of working and delivering outputs. Staff took on new roles/responsibilities at short notice to assist and in doing so increased their knowledge across H&SSG and the digital space. For KAS, working outside of normal contracted hours meant that they were able to deal with urgent queries to support H&SSG and the wider ECCW response in addition to resolving issues with the UK Government quickly.

5.3 Morale and teamwork within TAC was very high with most members believing their work was of significant importance. They found work interesting and rewarding and demonstrated considerable enthusiasm and dedication to their role.

5.4 Additional personnel were brought in to help SSID manage the response. Short term deployment was invaluable to the directorate as a whole. Many personnel were accessed from areas like Care Inspectorate Wales (CIW). Their background knowledge of the sector proved useful as personnel were able to quickly pick up work. The additional work streams exposed staff to new areas of work enabling them to work with new teams and make new connections, which was seen as positive and an opportunity for individuals own personal learning and development.

Suggestions for improvement:

- Clear roles and responsibilities going forward and training to support staff.
- Consider longer term implications for staffing, not just based on good will of staff.
- Capture and embrace key learning from staff that have been moved to critical roles.

Staff welfare/ resilience

5.5 There was a need to provide more support than usual within teams by being more flexible and recognising the challenges of working from home. For example individuals who were themselves shielding, or the impact on parents whose childcare arrangements had ceased and home schooling. Many teams kept in touch and support and welfare of staff maintained.

5.6 There was reliance on a fairly small number of staff working considerable long hours and regular weekend working. Whilst people "stepped up" and worked longer hours than

normal, it was a different kind of intensity as a result of remote working and has implications on the impact of staff for resilience and wellbeing. For some staff, responding to the new Covid-19 work in addition to BAU, created a lot of pressure and contributed to staff continuing to work very long hours, impacting on work life balance. Despite well-being messages it was very hard to achieve a balance when there was a lack of resource in critical areas.

Suggestions for improvement:

- Line managers to ensure check-ins are taking place and any well-being matters are addressed and staff continue to take annual leave. This should include those who have been deployed in and outside of H&SSG.

Planning of resources and challenges

5.7 It was often difficult to plan effectively for the amount of staff needed at times. There was lack of information on developments of the Covid-19 response shared widely with H&SSG staff. This was particularly the case with staff being moved into Covid-19 posts, leaving information gaps in what their new role was and who was picking up their work. The Business Directory was not updated to reflect this so it was often difficult to establish the relevant leads.

5.8 It took eight weeks into the response to sufficiently redeploy staff to the ECCW H&SSG Desk. This resulted in training on the job because there was insufficient time, which could have been avoided with the early redeployment of staff. Changing working patterns to work shifts took some time to adjust to. Whilst there appeared to be very little support or guidance at a senior level, staff supported each other.

5.9 The current pool of analysts in KAS is unlikely to be sufficient for future response. It experienced a shuffling round the existing pool of analysts, preventing radical decisions and ceasing important some work.

5.10 The ability to rapidly second individuals from the NHS Wales Delivery Unit to the Planning & Response Cell on a short-term basis provided flexibility and much needed capacity. The Health Emergency Planning Unit responded to support the ECCW arrangements and work on health countermeasures.

5.11 National (supporting) organisations such as HEIW, WHSSC, NWSSP, EASC and NWIS leaned in to provide much needed capacity, expertise and support to the Planning & Response Cell. These behaviours and ways of working set an important precedent for the emerging NHS Executive.

Suggestions for improvement:

- Sufficient staff resource to be made available across H&SSG, through a mix of the right level of staff from the outset of a response and by building teams from the start to prevent 'burn out'.
- Consider how to boost analytical capacity quickly within the organisation by bringing in additional resource from outside WG (TAC as well as KAS).
- Having a planned back-up for all staff in key roles will be important to guarantee continuity in case of unexpected staff absences.

Reacting to challenges

5.12 The management of handling of significant correspondence and government business, resulted in extreme delays and duplication. There was little resource available to deal with a very high volume of work. Some departments did not always take responsibility for their areas of work areas resulting in further delays and officials had to spend time having to negotiate transfers or contributions. Often staff had to develop lines to take and provide briefings with no knowledge of the subject matter.

5.13 The principle of a Covid-19 Planning & Response Mailbox was good but did not work in reality. It became just a generic place to send Covid-19 enquiries when people were not sure where to send, resulting staff taking many hours to try to work out the pathways to redirect queries and material to. The Mailbox was flooded with offers from the private and third sector and logging and acknowledging them became a huge task.

5.14 Roles were pretty blurred at times and often unclear what was required. Many staff took on new responsibilities so it was hard to track who was doing what. Perhaps too much focus on crisis management and not stepping back and thinking about what else really ought to be maintained.

5.15 TAC relied on a number of short term secondments and staff goodwill. The transient nature of some recent recruitments was very unhelpful for a critical area, which requires further longer term stabilisation. The team believes it has met its remit and made a significant contribution towards bringing the virus under control in Wales.

5.16 Issues started to arise when people were needed to start focusing on their "day job" instead of emergency response, which starts to highlight the frailty of analytical resources.

Suggestions for improvement:

- Ensure key stakeholders included in decisions pre-announcement.
- Do not stand back up a generic Covid-19 mailbox - it will force people to send the enquiry to the right person first time, to provide Ministers with high quality support and avoid reputational issues.
- Consider a better way of keeping Business Directory up to date so be able to identify leads for particular Covid-19 work areas.

6. Positive Outcomes

New ways of working

6.1 Remote working enabled stakeholders to capitalise new ways of working through digital technology, ensuring information could be cascaded to key stakeholders quickly including GP's Pharmacists, Dentists, Optometrists and community services. There has been a rapid transformation of mobile working capability to ensure that primary care and outpatients can consult with and treat patients remotely and has capacity for a large number of NHS Wales staff to work remotely. This has contributed to reduced risk of harm from missed NHS appointments.

6.2 Engagement with digital platforms and services has resulted in significant uptake across Wales of remote video consultations and the provision and use of devices in care home settings avoiding the need for vulnerable patients to leave their care homes.

Accelerating existing and planned digital programmes has the ability to achieve maximum benefit to both professionals and the public even with a limited timescale.

Communications

6.3 A professional communications service was provided throughout and clear messaging was conveyed as Wales diverged from UKG. The Keep Wales Safe campaigns, branding and work that has fallen under this in separate campaigns has been very effective and also adopted by stakeholders widely.

6.4 Insight from focus groups and polling shows WG approach to policy was favoured above the UKG and that messages were understood. It is thought that trust in WG is higher than in UKG.

6.5 Media communications proved successful with the Chief Nursing Officer (CNO) engaging via live radio news interviews, radio, public Q&A programmes, Twitter and by developing a range of filmed messages and webinar chats.

6.6 The ECCW H&SSG Desk made a significant contribution to the NHS not being overwhelmed at the peak and saving lives by enabling an effective flow of information between organisations and teams in a pressured environment.

NHS Staffing

6.7 The CNO led the response with the NMC Temporary Register to create additional staffing resource from return to practise staff and deployment of student nurses/midwives. The return of retired health professionals and return candidates to assist in the CMO team worked particularly well.

6.8 A significant achievement was that Coronavirus was brought under control and the NHS had the resources to cope.

6.9 Professional oversight of the nursing and midwifery professions were maintained and provided support and leadership as required, which contributed to national UK decisions affecting the professions.

Services, Guidance and Established Groups

6.10 Emergency workforce guidance is now in place to extend the critical care nursing workforce.

6.11 Ability to maintain oversight of maternity services, especially Cwm Taf Morgannwg as it is in special measures, was very good. Also maintaining oversight of serious incidents reported.

6.12 The CNO/ Deputy Chief Medical Officer chair of the Nosocomial Transmission Group provided multiple outputs and advice, e.g. advice on enacting distancing guidance within NHS estate.

6.13 The NHS response has been significant - maintaining critical care capacity, supplies etc. Teamwork and determination shone through.

Data

6.14 A significant amount of data was made available publicly ensuring that Ministers were able to quote figures that were publicly available to all; transparency and openness; allowing government to be held to account.

6.15 Close working with KAS and CIW led to transparency over care homes data. Early engagement with KAS was essential to ensure appropriate analytical engagement with TAC and SAGE. KAS role on TAG was important to provide perspective from a government analytical function alongside academic and other experts.

6.16 Including analytical staff in some of the regular meetings on cross cutting areas (e.g. Vulnerable People cross government group, Safeguarding and Vulnerable children, and Covid-19 BAME groups) enabled better understanding of rapidly changing context and ability to tailor analytical support.

6.17 SSID established new Social Care Covid-19 data collection to support policy and prevent duplication, which has proved invaluable to inform the sector, the response and to support Ministers, policy leads and senior leaders. It has further enhanced and highlighted the need for consistent, robust and timely social care data in Wales, which SSID is pursuing through the development of the Social Care Performance and Improvement Framework and the National Data Strategy (which is currently being developed by Social Care Wales).

Good practice

6.18 LA leadership alongside NHS organisations ensured a people/community focus and good communications.

6.19 New ways of working during the Covid-19 outbreak have reflected the policy aims of "A Healthier Wales", in particular regarding 'closer to home' ways of delivering services.

6.20 The setting up of a safeguarding cross departmental Vulnerable Families Group aided joint decision making and information sharing and has worked well in bringing all interested parties together, avoiding duplication and ensuring a consistent message is shared with policy leads and with stakeholders.

6.21 SSID already had response structures in place due to planning and preparedness for Brexit, which was valuable in helping quickly stand up a social care coordination hub/ staff/ mailbox as the roles and remit of the hub had already been drafted.

SECTION 4 – SUMMARY OF RECOMMENDATIONS

The key recommendations have been identified from the response findings in the scope of the review. These are strategic aims for consideration on how H&SSG can continue to respond effectively to the Covid-19 response and make improvements to react to possibly a second wave of Covid-19 and similar or concurrent incidents in future.

1 Incident Response

Area	No.	Issue	No.	Recommendation
Incident response	**1**	H&SSG needed to quickly redeploy resources with key areas coming under pressure including public health, communications, social services and the work streams which evolved continuously. As the situation and response mechanisms evolved, there was some overlapping of roles and responsibilities including, for example, between the Planning & Response Group/Cell and WG project COVID team.	**1**	H&SSG to consider its contingency structure for resurgence of COVID-19/winter (page 3) and review and update the COVID-19 Planning & Response Framework accordingly in readiness for the next phase of the pandemic response, as well as providing a template for any future public health emergencies.
	2	The Group's "Arrangements for Responding to Emergencies" sets out tried and tested initial response measures for establishing the H&SSG Desk in ECCW. This response did not go as planned with staffing of the Desk initially stalling and at times there was inadequate cover and right level and mix of staff. The Group's emergency response "arrangements" addressed our immediate response requirement but the experience of COVID has demonstrated the need for longer term emergency planning to ensure our response is sustainable and resourced sufficiently. This longer term emergency planning needs to build on the close working relationship with NHS and Social Services.	**2** **3** **4**	Review the H&SSG Desk arrangements and clarify accountabilities, responsibilities and resourcing of this response. Develop H&SSG emergency plans for the medium and longer term response to emergencies to ensure the Group is capable of sustaining its response. Consider the role that a NHS Executive function should have in our emergency response in providing a formal and resourced interface between H&SSG and NHS organisations.
	3	The protocol with Public Health Wales would benefit from being revisited as responsibilities for public	**5**	Review the protocol with PHW and also the structure and staff resilience of the Public Health Division to

Area	No.	Issue	No.	Recommendation
		facing communications (dashboards/webpages) have become blurred over time. Public Health Division (Health Protection and Health Emergency Planning) staff came under severe pressure and needed additional staff resources.		deliver health protection and emergency planning functions.
	4	DHSC is the lead UK Government Department for a pandemic and did co-ordinate a 4 countries approach to pandemic planning. DHSC co-ordination of the response across the 4 countries was less clear.	**6**	Clarify with DHSC the structure for 4 countries co-ordination of the response through the winter and for future national emergencies.
	5	Data information, dashboards and reporting took some time to develop and data requirements of the UK Government were different to those being used in Wales. The establishment of the Technical Advice Cell placed additional data requirements that needed to be addressed. There also appeared to be a number players in the statistics, data and evidence reporting space. For example there were multiple reporting lines to Ministers via the NHS performance team, public health team, KAS and PHW, which may possibly have contributed to the issues that arose around mortality surveillance.	**7**	Review H&SSG data and dashboard requirements and their purpose. Clarify the responsibilities of those involved including KAS, NWIS, PHW, Digital Cell, TAC and others.
Policy Development	**6**	The COVID response necessitated sub groups and cells being established quickly which cut across policy areas and did not always take account of existing policy responsibilities. For example, the primary and community care sub group work inevitably impacted on areas normally covered by deputy directors' accountabilities.	**8**	Through the Planning and Response structure proper account is taken of the policy areas affected so that the accountabilities of the planning and response groups/cells and policy interests are clarified.
Communication and Engagement	**7**	The amount of emails having to be dealt with, logging of actions and mailbox enquiries proved to be major challenges across the Group. The various dashboards that appeared, reports and situation updates threatened information overload and	**9**	Establish a stakeholder group to review the significant challenges of managing information and dealing with enquiries so that improvements are made and there is a clarity of the process going forward through winter.

Area	No.	Issue	No.	Recommendation
		confusion. The role of PHW in providing public information needs to be clarified and ways sought to deal with extreme volumes of enquiries and clearer process for dealing with media and ministerial requests.		
	8	There is an issue as to how best we align with the healthcare system going forward to continue the sustained level of stakeholder engagement that has been achieved through COVID. This engagement has been essential in our agility of response and in communicating and engaging with the service when making decisions such as: • Roll-out of GP connect • Collective commissioning of private hospital capacity • Recruitment of students and recent retirees • BAME workforce risk assessment tool • PPE distribution Such engagement was also crucial in deciding when not to progress something, such as Wales opting for a local, distributed model of field hospitals to provide step down care, instead of larger, centralised nightingale facilities providing critical/ acute care as decided in England.	**10**	Consideration is given to the structure for engaging with stakeholders that has been at the core of our response to COVID thus far, through the next phase of COVID and in the longer term for routine business. The proposals for the creation of a NHS Executive should be integral to these considerations.
People and Skills	**9**	COVID resulted in a flexible response from staff and people were asked and did take on new and very different roles under pressure. Key individuals played a significant part in the response and many were fast tracked into roles that were unfamiliar to them. There continues to be a need to resource essential elements of our response such as our Technical Advice Cell, Test, Trace and Protect	**11**	Directors review their workforce and implement appropriate, measures to ensure resilience and adequate staff cover for key areas and any necessary training is provided. Update the business directory so as to provide clarity on individual COVID roles and responsibilities.

Area	No.	Issue	No.	Recommendation
		function and the planning and response cell and this resourcing will need to be sustained for some time to come.	**12**	H&SSG Workforce and Corporate Business lead work with Directors to identify capability and capacity gaps in staffing and raise corporately into WG the staffing requirements of key elements of our response where these cannot be met from within the Group's resources by reprioritisation and redeployments.
Governance and Accountability	**10**	H&SSG incident response was complex and developed at pace. This produced challenges in clarifying policy accountability and governance, confirming roles and responsibilities and establishing co-ordination of the Group's response. The strategic, tactical and operational aspects and their linkage should be known.	**13**	The leadership and co-ordination role of EDT in the COVID response and through winter should be more visible and understood across H&SSG. The delegated responsibilities of members of the Executive Director Team (EDT) should be set out and agreed.
			14	EDT members should undergo some crisis management training commensurate with their accountabilities.
			15	The communications and reporting arrangements across H&SSG (see page 3) for winter through to EDT should be confirmed.
			16	H&SSG Directors should identify a senior member of staff to be part of a cross Directorate standing emergency planning group to ensure Directorates are sighted on national risks and can plan accordingly. This emergency planning group should be chaired by an SCS official.

ANNEX A

Key stakeholders for the H&SSG response to COVID lessons learnt exercise:

Key Individuals

HSSG COVID-19 Planning & Response Cell
Samia Saeed-Edmonds, Chair, Planning Programme Director
David Goulding, Health Emergency Planning Advisor
Name Redacted Vice Chair, Deputy Director, Healthcare Quality Division
Name Redacted Head of NHS Wales Operational & Strategic Planning
Name Redacted Planning and Delivery Lead
Name Redacted Head of Planning
Name Redacted Senior NHS Planning Manager
Name Redacted National Clinical Plan, Strategic Planning Lead
Name Redacted Planning and Response Cell Support
Name Redacted Planning and Response Cell
Name Redacted Planning & Response Cell

Technical Advisory Cell
Rob Orford, Chief Scientific Adviser for Health
Fliss Bennee, Co-Chair, Technical Advisory Cell Covid-19 ECCW

PPE
Alan Brace, Chair of PPE Supply Cell, Director of Finance
Name Redacted

Health Countermeasures
David Goulding
Name Redacted
Andrew Evans

Social Care
Albert Heaney
Andrea Street
Name Redacted

Primary & Community Care Cell
Alex Slade
Name Redacted

Acute Secondary Care Cell
Dr Chris Jones and Andrew Sallows,

Workforce Deployment & Well-being Cell
Helen Arthur and Name Redacted

Digital Cell
Ifan Evans and Helen Thomas

Essential Services
Janet Davies and Mark Dickinson (NHS Collaborative)

Nosocomial Cell
Dr Chris Jones and Jean White

Health Desk main/core volunteers

Name Redacted

Public Health emails response/correspondence
Nick Thomas

Health Emergency Planning Unit

Name Redacted

Testing & Tracing
Claire Chappell
(Claire Rowlands) already on list

Name Redacted

CMO team
Ffion Thomas

Name Redacted

Covid Bill
Neil Surman and Name Redacted

Public Health Division COVID Response
Chrishan Kamalan
Peter Jones
Neil Surman
Name Redacted Head of Health Protection
Name Redacted Senior Environmental Health Advisor for Covid-19
Marion Lyons, Senior Medical Officer
Name Redacted Senior Executive Manager, Health Protection
Name Redacted Senior Environment and Health Policy Manager

Population Health
Heather Payne, Senior Medical Officer for Maternal & Child Health
Name Redacted Head of Healthcare Quality Development

Communications
Name Redacted

KAS
Glyn Jones and Stephanie Howarth

Questions/ Correspondence
Name Redacted

Medical Directors and leads
Andrew Sallows, Delivery Programme Director
Colette Bridgman, Chief Dental Officer
Andrew Evans, Chief Pharmaceutical Officer
David O'Sullivan, Chief Optometric Adviser
Alexander Slade, Deputy Director for Primary Care
Mark Walker, Senior Medical Officer for Primary Care
Claire Rowlands
Brendan Collins
Dr Elizabeth Davies

EDT Members
Name Redacted
Jo-anne Daniels
Jean White