Witness Statement of: Andrew Goodall
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF ANDREW GOODALL

I, Andrew Goodall, will say as follows:

1. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 referenced M2B/HSSG/01.

Preface

2. First and foremost, I would like to express my sincere sympathies to those who were affected by and lost loved ones because of the Covid-19 pandemic. The nature of the pandemic invariably placed a huge demand on the health and social care sector in Wales and on those civil servants in the Welsh Government Health and Social Services Group ("HSSG") supporting the sector throughout the pandemic. I cannot overstate the fast-moving nature of the environment both internally in the Welsh Government and externally in these sectors, however at all times the HSSG tried to act appropriately, using the data and evidence available, to discharge a responsibility to protect the population of Wales.

3. This statement addresses the specific role of the HSSG in relation to decision-making by the Welsh Government in respect of the imposition or non-imposition of non-pharmaceutical interventions ("NPIs"), between early January 2020 and May 2022 ("the specified period"). I held the position of Director General of Health and Social Services ("the Director General HSS") from June 2014 to November 2021 after which I took up the position of Permanent Secretary and, as such, consider myself the

appropriate person to speak to the tremendous efforts made by the HSSG during the specified period. In doing so of course, I would wish to acknowledge the exceptional efforts and activities of public service staff across Wales, notably in this context the NHS and social care sector.

4. Module 2B is concerned with systems and structures, therefore, this statement will not examine in detail the role of the HSSG in relation to implementation of health or social care strategy and policy, although some examples will be provided but will by no means be an exhaustive list of HSSG activities, which will addressed in full as the subject of later modules for consideration by the Inquiry.

5. To date I have provided seven corporate statements to the Inquiry (including this corporate statement) which describe the functions and infrastructure of the Welsh Government and how these were deployed to prepare for and respond to the pandemic. I have also now provided a separate, personal statement to the Inquiry in relation to module 2B (M2B/WG/AG/01). In respect of the corporate statements, I provided three statements to the Inquiry in connection with module 1 (M1/WG/01, M1/NHSWALES/01, and CSOCSAWALES/01) and now four statements in connection with module 2B (M2B/WG/01, M2B/WG/WT/01, M2B/NHSW/01 and this corporate statement, M2B/HSSG/01). Each of these statements reflect, to a greater or lesser degree, my professional experience in the Welsh Government. Whilst this corporate statement (and M2B/NHSW/01, which details NHS Wales' response to the pandemic) are both provided in my capacity as someone intimately involved with, and with oversight over, specific functional parts of our infrastructure (as Director General of Health and Social Services and NHS Wales Chief Executive, prior of course to Judith Paget's stewardship) the other corporate statements provide a more factual account of aspects of the Welsh Government's functions, powers, structures and processes with which I was not so closely involved (such as my statements on the Welsh Government's preparedness for whole-system civil emergencies for module 1 of the Inquiry).

6. In my statement to the UK Covid-19 Inquiry ("the Inquiry") referenced M2B-WG-01 I have provided an overview of the Welsh Government's organisation, structures, functions, governance and decision-making processes, which informed the response to the Covid-19 pandemic. The HSSG role was to support Ministers in the decision-making process and as such had a role in, gave advice on, and participated in broader discussions about the imposition or non-imposition of NPIs. This role was not however exclusive to the HSSG and, as the HSSG is part of the Welsh Government, this

statement should be read alongside the Welsh Government corporate statement (M2B-WG-01) and the other corporate statements provided to the Inquiry relating to the other directorates in the Welsh Government to fully understand the structures in which the HSSG operated and the other groups and directorates with whom they worked with.

7. As I outlined in M2B-WG-01, 'Leading Wales out of the Coronavirus pandemic; a framework for recovery' (**AGM2BHSSG01/1-INQ000083221**, dated 24 April 2020) described the Welsh Government's intended approach to leading Wales out of the pandemic. The recovery framework was based on three pillars which were:

    i. Measures and evidence: the measures and evidence by which the Welsh Government would judge the capacity to respond to and assess infection levels and transmission rates for coronavirus in Wales.

    ii. Principles and underpinning adjustments to restrictions: a series of principles by which the Welsh Government would examine proposed measures to ease the then existing restrictions, grounded in both scientific evidence and wider social and economic impacts.

    iii. Public health purpose: a description of how the Welsh Government would enhance its public health surveillance and response system to enable it to closely track the virus as restrictions are eased, and how the system would protect people's health.

8. The HSSG work linked closely to all three pillars. Pillar one considered the NHS's capacity which was closely monitored by the HSSG from the outset of the pandemic. HSSG officials worked alongside stakeholders and the health and care system to identify ways to build additional capacity and resilience. Consideration of NHS hospital capacity included supporting the social care sector, primary care and community services in order to protect the integrated health and care system from becoming overwhelmed.

9. In respect of pillar two, the Chief Medical Officer for Wales ("CMO(W)") and Chief Scientific Adviser ("CSA") for Health advised ministers. This statement will not rehearse the medical, scientific or other expert evidence that was available in the context of NPIs which sits more suitably with the CMO(W) and the CSA for Health, who I understand have also received request for information from the Inquiry, but both

were key officials in the HSSG and worked in close collaboration with others within the HSSG, which will be outlined in this statement.

10. Finally, pillar three involved the work of Public Health Wales and HSSG officials working on contract tracing in Wales which provided essential information on the transmission of the virus in Wales and the effectiveness of the impositions put in place. When the vaccination programme commenced and vaccine status was linked with contract tracing this gave us a better understanding of the impact of the vaccine on transmission and NHS capacity, providing essential triangulation and assessment.

11. Our response was informed and improved by the views and expertise of those working in health and care system organisations and professions, balancing internal roles with external organisations and stakeholders and culminated in the information and recommendations put to ministers to inform decisions on the imposition and non-imposition of NPIs.

Introduction

12. My education and experience are set out in my statement referenced MB2-WG-01 and my personal statement to the Inquiry but I will here expand on my role as Director General HSS which includes the role of Chief Executive NHS Wales, a position that I had held from June 2014 to November 2021. The Director General HSS is a combined role as Director General and a role referred to as the "Chief Executive of the NHS Wales". The role of Chief Executive of the NHS Wales is however not a statutory role. This structure has been in place over many years including for my predecessors and was not uniquely in place during my tenure or for the pandemic response. However, in my view the role gave the opportunity to bring together NHS expertise and insight alongside ensuring the best advice was made available to ministers.

13. The term "NHS Wales" is commonly used to collectively refer to Local Health Boards, NHS Trusts and Special Health Authorities (collectively "the NHS bodies") and those who they contract with to provide a range of primary, secondary, and specialist tertiary care services and community services including district nurses, health visitors, midwives, community-based speech therapists, physiotherapists and occupational therapists. There is however no legal entity of this name.

14. The only body which has overarching responsibility for the NHS in Wales is the Welsh Government. The position is fundamentally different for social services and social care

for which the Welsh Government is responsible for the policy but not the delivery. Responsibility for the delivery of social care in Wales lies with the local authorities.

15. In my capacity as the Chief Executive of NHS Wales, I was accountable to the Minister for Health and Social Services, and responsible for providing policy advice and exercising strategic leadership and management of the NHS in Wales.

16. The role of Chief Executive NHS Wales is essentially outward facing as the representative of NHS Wales. I was designated as the "Accounting Officer for the NHS in Wales" and in that role I was personally responsible for the stewardship of funds for the NHS in Wales. The Chief Executive Officer of an NHS body performs the role of the body's Accountable Officer and was in turn accountable to me as the Accounting Officer for the NHS in respect of the body's functioning and expenditure.

17. The Director General HSS role is inward facing, as the senior civil servant in the HSSG. In the context of the pandemic, in this role of Director General HSS I had responsibility for:

    i. Enabling intergovernmental decision-making for health and social care;

    ii. Oversight to how health and social care decisions were made, communicated and implemented;

    iii. The availability and use of data and evidence;

    iv. Shielding and the protection of the clinically vulnerable;

    v. Preparedness, NHS initial capacity and ability to increase capacity and resilience;

    vi. The management of the pandemic in all health care settings, including infection prevention and control, triage, critical care capacity, the discharge of patients, the approach to palliative care, workforce testing and changes to inspections

    vii. the impact on staff, staffing levels and workforce wellbeing;

    viii. Contributing to the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings from a health perspective;

ix. The procurement and distribution of key equipment and supplies, including PPE and ventilators;

x. The consequences of the pandemic on provision for non-Covid-19 related conditions and needs including the maintenance of essential services; and

xi. Supporting all Directors in my team to discharge their responsibilities, including the Public Health Directorate and line management of the CMO(W) .

18. I held the role of Director General HSS/Chief Executive NHS Wales until November 2021 when I started as Permanent Secretary and was succeeded as Director General HSS /Chief Executive NHS Wales by Judith Paget.

19. Preparing this corporate statement, I have relied on advice and information from members of the HSSG Senior Civil Service team. This includes Judith Paget, the current Director General HSS and Chief Executive NHS Wales who has provided input on the period from November 2021 when she took up the position. Samia Edmonds, NHS Planning Director has also provided information on the work of the Health and Social Services Covid-19 Planning Response Group which she chaired, and finally Sioned Rees, Director of Health Protection, Mental Health and Primary Care has provided overall input. As Director General HSS I of course engaged with a wider group of individuals across the directorate which I have detailed further in this statement below.

Overview of legislative framework for health and social services in Wales

20. My Director of Legal Services, Helen Lentle, has provided a detailed statement to the Inquiry which sets out the legislative history of devolution in Wales alongside a full explanation of the current statutory framework under the Government of Wales Act 2006 ("GoWA") (as amended) that constitutes the Welsh Government and provides the Welsh Ministers with their executive competence. I therefore do not propose to rehearse, in this statement, the legal elements of the Welsh devolution settlement that have been covered elsewhere other than to note that health and social services have been devolved functions since 1999[1].

21. While there is a body of extant pre-devolution legislation relating to health and social care which still applies in Wales, the principal governing legislation for Wales in relation to health care, is the National Health Service (Wales) Act 2006 ("the 2006 Act"); and

[1] National Assembly for Wales (Transfer of Functions) Order 1999 (SI 1999/672)

in relation to social care, the Social Services and Well-being (Wales) Act 2014 ("the 2014 Act"). In relation to public health there is also a body of extant legislation but, for the purposes of this statement, the most relevant is the Public Health (Control of Disease) Act 1984, under which the Welsh Ministers have a range of regulation making powers.

22. The Welsh Ministers are responsible under the 2006 Act for the provision of a comprehensive health service in Wales. Under the 2014 Act the Welsh Ministers have a general supervisory role in the current system of social care provision in Wales, however provision of social care in Wales is the statutory responsibility of local authorities in Wales, as detailed below.

Integration of Health and Social Care in Wales

23. The policy and recent legislation in Wales relating to the health and social care system has been designed to reflect the clear objective in Wales to integrate health and social care services, the purpose of which is to secure better joint working and ensure effective services which best meet the needs of the local population.

24. In 2018, 'A Healthier Wales', our Long-term Plan for Health and Social Care was published by the Welsh Government in response to the commitment under Prosperity for All, the Welsh Government's Programme for Government, to further integrate health and social care, building on the work of the Parliamentary Review into Health and Social Care. This complemented the provision in the 2014 Act, a key principle of which was the requirement for integrated and sustainable care and support services. A Healthier Wales refers to seamless health and social care promoted by and through Regional Partnership Boards. The 2014 Act had provided for the establishment of seven Regional Partnership Boards, on the health board footprint, which brought together health boards, social services, third sector and other partners[2]. Regional Partnership Boards jointly assess, plan and provide efficient and effective services for their area with the purpose of improving the outcomes and well-being of people with care and support needs, and carers who need support.

25. The 2014 Act also seeks to ensure that a population assessment by each Regional Partnership Board is taken into account as part of broader integrated planning frameworks, for example, within Local Well-being Plans (required under the Well-being

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[2] The Partnership Arrangements (Wales) Regulations 2015 ("the 2015 regulations") prescribe the requirements for each Local Health Board and the local authorities within their area to take part in partnership arrangements for the carrying out of specified health and social services functions.

of Future Generations (Wales) Act 2015[3]) and the NHS Integrate Medium Term Planning requirements (detailed further below). Local authorities and Local Health Boards must jointly produce and publish a report of the outcome of their population assessments.

26. While funding mechanism for health services and social services differ, since 2014 there has been investment by the Welsh Government through various health and social care funding streams (e.g., Integrated Care Fund, Transformation Fund and Digital Priorities Investment Fund) to progress the integration of health and social services in Wales. These funding streams were built upon and scaled up at pace in response to Covid-19.

27. The Integrated Care Fund has been running since 2014 with the aim of assisting Regional Partnership Boards and encouraging collaborative working between social services, health, housing, third sector and independent sectors. The Transformation Fund is the key funding mechanism to support the implementation of a Healthier Wales, with its objective of enabling the scaling of new models of care to regional and in some cases national footprints, and thereby changing the way health and social care are delivered in Wales. The purpose of the Digital Priorities Investment Fund is to make strategic funding available for digital priorities in health and social care, in response to a headline commitment in A Healthier Wales to 'significantly increase investment in digital'.

28. During the Covid-19 response, while it remained the responsibility of local authorities to use their local allocations to ensure local resilience of their social care system, given the exceptional circumstances, funding was channelled through these funding streams driven by HSSG policy. Funding to Regional Partnership Boards via these funding streams enabled health and social care to quickly adapt to new ways of working to ensure the safest possible options for staff and patients / citizens using health and social care services.

Health service in Wales

29. The HSSG is responsible for setting policy and standards to promote high quality, safe services based on population health need. The HSSG sets out the Minister for Health and Social Services 's expectations in respect of planning and performance and seeks

[3] See Section 30(3) of the Well-being of Future Generations Act 2015.

assurance from NHS organisations through planning, delivery and compliance frameworks.

30. As noted above, the Welsh Ministers provide health services through a network of NHS bodies including primary care providers, dental providers, optometrists and other healthcare providers by conferring functions on NHS bodies or entering into contractual arrangements with providers.

31. There are three kinds of NHS bodies under the 2006 Act: Local Health Boards, Trusts and Special Health Authorities. The Welsh Ministers establish these bodies and give them their functions. Not all these bodies necessarily care for patients or provide a health service in a clinical sense. In Wales healthcare services are primarily delivered by Local Health Boards who have a role as both the commissioner and provider of services in their areas, with responsibility for the health of their local population. This includes primary, community, acute and mental health services. A Trust or SHA may, for example, carry out technical or administrative services and not provide any patient-facing services. In Wales there are three NHS trusts: Public Health Wales NHS Trust, the Welsh Ambulance Service Trust and Velindre NHS Trust. There are two Welsh Special Health Authorities: Health Education and Improvement Wales ("HEIW") and Digital Health and Care Wales ("DHCW"). There are also two joint Special Health Authorities operating on an England and Wales basis: the NHS Business Services Authority and NHS Blood and Transplant.

32. In addition to the above statutory bodies there are a range of committees and partnerships in place which also service the NHS Wales, the principal ones being:

    i. NHS Wales Shared Services Partnership Velindre NHS Trust has the function of managing and providing shared services to the health service in Wales. NHS Wales Shared Services Partnership is the operational name for the Shared Services Committee of Velindre NHS Trust. NHS Wales Shared Services Partnership includes the provision of payroll services, procurement services, and legal services for NHS bodies in Wales.

    ii. Welsh Health Specialised Services Committee ("WHSSC") - The Welsh Ministers made Welsh Health Specialised Services Committee (Wales) Regulations 2009 so that the seven Local Health Boards in Wales work via a joint committee to exercise functions relating to the planning and securing of specialised and tertiary services. Welsh Health Specialised Services

Committee is hosted by Cwm Taf Morgannwg University Local Health Board. The role of the Committee is akin to that of NHS England in managing a budget for the commissioning of specialist services on a national level.

33. Additionally, there are a range of national committees or "all-Wales" groups with responsibility for various aspects of NHS delivery. For example, the NHS Wales Delivery Unit provides support to the Welsh Government in monitoring and managing performance delivery across NHS Wales, and the All Wales Medicines Strategy Group advises on use, management and prescribing of medicines, and the 1000 Lives Improvement[4] supports improvements in health and social care across Wales. A governance map of the NHS in Wales (dated 21 April 2021) is exhibited at **AGM2BHSSG01/2-INQ000083222**. This statement does not provide and exhaustive list and many of these groups and committees will be more relevant to module 3 to the Inquiry which will examine in more detail the role of the health care system during the pandemic.

34. In respect of NPIs, whilst the overall NHS system had a role to influence and contribute (particularly in relation to the assessment of NHS capacity which was fundamental to assessing the available headroom for the imposition or non-imposition of NPIs), Public Health Wales had a specific national role in the provision of expertise and advice, including advice on infection prevention control, control measures, vaccination and a range of other related issues. Additionally, NHS Wales Shared Services Partnership worked closely with HSSG officials around the procurement of PPE supplies and other critical care supplies.

35. NHS bodies are directly funded by the Welsh Government to deliver the Welsh Ministers priorities on behalf of the people of Wales. In my second statement to the Inquiry relating to the Welsh Treasury, reference M2B-WT-01, I have outlined in detail the sources of funding to the Welsh Government.

36. NHS bodies are required to produce an annual, formal statement of assurance known as the Annual Governance Statement, signed by the Chief Executive on behalf of the organisation, and published as part of its annual accounts. The statement on internal control provides citizens and other stakeholders with a level of confidence on the way in which an organisation is led, the efficiency and effectiveness of its operations and ultimately, its ability to deliver its strategic vision, aims and objectives. Boards of NHS

[4] Renamed 'Improvement Cymru'

organisations are also required to publish a public Annual Quality Statement. This statement sets out clearly the achievements and challenges over the previous year, as well as the improvements the Board has agreed to make in the year ahead, to continuously improve the delivery of high quality and safe services.

37. The Welsh Government's NHS Wales Planning Framework gives guidance to Local Health Boards on developing three-year plans, known as Integrated Medium Term Plans ("IMTPs") setting out how they will deliver services to meet the needs of their local population. The NHS Planning Frameworks for the specified period are exhibited at **AGM2BHSSG01/3-INQ000083223** (dated 20 September 2019) **AGM2BHSSG01/4-INQ000083224** (dated 14 December 2020) and **AGM2BHSSG01/5-INQ000083225** (dated 1 December 2021). The Welsh Ministers approve the annual Integrated Medium Term Plans for each Local Health Board, and each Local Health Board delivers agreed plans within their allocated budgets. The Welsh Ministers report to the Senedd before the end of any three-year accounting period on whether each Local Health Board has complied with its statutory duty to break even[5]. The same duty applies to NHS trusts.

38. A particular (and, possibly, defining) feature of the Welsh public healthcare sector is that, consisting only of 12 bodies, it is intimate. We were able to use existing arrangements between the Welsh Government and the bodies for regular and effective two-way communication to identify and resolve problems quickly. Prior to the Covid-19 pandemic I chaired the monthly NHS Executive Board meetings attended by the respective individual Chief Executives for the NHS bodies in Wales (this board was renamed in June 2021 the NHS Leadership Board). The Board was a formal meeting for which an agenda, papers and minutes were circulated. Beyond formal mechanisms, the proximity of the healthcare system to government also enabled speedy contact and discussion when needed, with organisations, stakeholders and professional representatives. This put us in a strong position in terms of existing relationships and mechanisms when the pandemic hit, which I will outline further below.

Social services in Wales

39. Social services in Wales are delivered by the 22 local authorities in Wales as detailed in exhibit **AGM2BHSSG01/6-INQ000083226** dated February 2019. Statutory responsibilities for social care are vested in local authorities under the Social Services

[5] Under section 175(1) of the 2006 Act.

and Well-being (Wales) Act 2014, as supplemented by regulations, statutory guidance and codes of practice made under that Act.

40. The 2014 Act and the approach to social services in Wales differs from that in England. In Wales we have moved away from the concept of 'care' and more to the concept of 'well-being'. The 2014 Act requires persons exercising functions under the Act to promote the well-being of people who need care and support, and that of carers who need support. This overarching well-being duty applies to all persons and bodies exercising functions under the 2014 Act, including the Welsh Ministers, local authorities, Local Health Boards and other statutory agencies.

41. Well-being under the 2014 Act covers a wide range of the aspects of daily life such as physical, mental and emotional well-being, protection from abuse, and family and personal relationships. Additionally, there are overarching duties to have due regard to the United Nations Principles for Older Persons[6] and the United Nation Convention on the Rights of the Child[7]. Decisions during the pandemic needed to be made with these duties in mind and formed part of the Welsh Government's approach to balancing the harms of Covid-19, which I detail further later in this statement.

42. The duty on local authorities to provide social services encompasses a wide range of services. Section 34 ('How to meet needs') of the 2014 Act provides examples of the kinds of services that may be provided under the 2014 Act, including:

    a. accommodation in a care home, children's home or premises of some other type;

    b. care and support at home or in the community;

    c. services, goods and facilities;

    d. information and advice;

    e. counselling and advocacy;

    f. social work;

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[6] Section 7 of the 2014 Act

[7] Section 7 of the 2014 Act, note that section 6(3) of the Act notes the duty to have due regard to the UNCRC will be in the form set out in the Rights of Children and Young Persons (Wales) Measure 2011, which includes the UNCRC optional protocols.

g. payments (including direct payments);

h. aids and adaptations; and

i. occupational therapy.

43. The 2014 Act requires local authorities, when exercising social services functions, to act in accordance with any relevant requirements contained in the statutory guidance or a code issued by the Welsh Ministers and to have due regard to any relevant guidelines contained in it[8].

44. As touched on above, social service and social care in Wales operated in a fundamentally different way to health services. Social services are primarily funded by local authorities via the Revenue Support Grant and local government allocations in the discharge of their legal duties for population need based on local government decisions. My role as Director General HSS covered the social service and social care policy issues rather than operational delivery of services, responsibility for which sat solely with the local authorities in Wales.

45. Supporting me in this role was Albert Heaney, who was Director of Social Services and Integration until March 2020. Recognising the enhanced support, the NHS would require from March 2020 and the need for me to lean into the Chief Executive NHS Wales role more, I asked Albert Heaney to take up the post of Deputy Director General, Health and Social Services to ensure that the social care sector had dedicated support at this senior level. Albert continued in this role until June 2021 and was appointed the Chief Social Care Officer for Wales. I understand that Albert has provided evidence to module 2B and I am sure will expand on his role and support to the social care sector during this period, which will also be considered further in Module 6 as well. All of these roles reflected his significant background and experience in this sector.

46. The Social Services Directorate had well established stakeholder relationships and communications channels. These included regular meetings and communication with statutory directors of social services and the Association of Directors of Social Services (ADSS) Cymru. In addition, a Ministerial-level National Partnership Board was established comprising representative social care stakeholders, together with Ministerial advisory forums and groups, for example in relation to learning disability, older people, looked after children, and unpaid carers. Frequent meetings were also

[8] Section 145 of the 2014 Act.

held with a wide range of stakeholders across statutory Commissioners and provider representative organisations via the National Commissioning Board, Regional Partnership Board leads and chairs, local government partners and Welsh Local Government Association members, third sector organisations, and service user representatives at official and Ministerial levels.

47. This pre-existing infrastructure and approach was extensively supplemented by bespoke mechanisms such as the Covid-19 Planning and Response Social Care Subgroup outlined below in paragraph 101. This group advised both on pandemic response and also in relation to lessons learned after the first phase. A further layer of additional engagement was provided by a major uprating of existing engagement such as weekly meetings hosted by both the Deputy Minister and Deputy Director General with the Older People's Commissioner, and weekly Ministerial meetings with representatives of social care providers, as well as the establishment of the Social Care Testing Leads forum which included testing leads from local authorities and Local Health Boards.

Structure of the Health and Social Services Group

48. The HSSG supports the Welsh Ministers and reports to the Minister for Health and Social Services progress against Ministerial priorities. The Minister for Health and Social Services is responsible for the NHS in Wales, including all aspects of public health and health protection in Wales, and for policy and oversight of the provision of all social service activities of local authorities in Wales, including the issue of statutory guidance. This Ministerial position was held by Vaughan Gething MS from 2016 to 12 May 2021 when he was replaced by Eluned Morgan MS, Baroness Morgan of Ely.

49. The HSSG has a unique role within the Welsh Government in that it is responsible for exercising strategic leadership and oversight of the NHS in Wales and is responsible for the robust stewardship of NHS funds. The HSSG is also the link between the local authorities' social services directors and the Minister for Health and Social Services and Deputy Minister for Health and Social Services. In October 2020, when the new Minister for Mental Health, Wellbeing and the Welsh Language was appointed the HSSG also supported her with mental health and well-being already being an established part of the HSSG remit.

50. The group has the following overarching responsibilities:

i. promoting, protecting and improving the health and well-being of everyone in Wales, and leading efforts to reduce inequalities in health;

ii. making available a comprehensive, safe, effective and sustainable National Health Service;

iii. ensuring that high quality social services are available and increasingly joined up with health care and other services; and

iv. ensuring that through Cafcass Cymru, children are put first in family proceedings, their voices are heard and decisions made about them by courts are in their best interests.

51. Prior to the pandemic the HSSG consisted of the following divisions:

i. Cafcass Cymru;

ii. Delivery, Performance and Planning for health and care in Wales;

iii. Finance;

iv. Mental Health, Vulnerable Groups and NHS Governance;

v. Nursing;

vi. Population Health (including Chief Medical Officer Office);

vii. Primary Care and Health Science;

viii. Social Services;

ix. Technology, Digital and Transformation; and

x. Workforce and Organisational Development.

52. The role of the HSSG is to focus on supporting the Welsh Government to deliver its priorities, whilst also providing leadership to the NHS and Social Services system in Wales to ensure they can deliver the required changes in services and culture. These changes and system expectations are set out in a Healthier Wales. Much of the work of the HSSG will be relevant to later modules such as the healthcare systems module which will further consider the work of the Mental Health, Vulnerable Groups and NHS Governance, Nursing, Primary Care and Workforce. The later care module will

highlight the significant work by the Social Services team in HSSG and the health inequalities and impact of Covid-19 will also have cross cutting significance across the HSSG. In this statement any omission of the activity in these divisions is due to the scope of module 2B and not reflective of inactivity in anyway.

HSSG Covid-19

53. At the start of the pandemic, our working assumption for plans and system actions was that the first wave would last a short intense period with a peak (which the Scientific Advisory Group for Emergencies ("SAGE") expert modelling for the UK indicated would be between 2 to 3 months from the onset of sustained human-to-human transmission in the UK) that would need urgent action to mitigate the expected impact on the population and services. That was based on our pandemic planning assumption and previous civil contingency experience, but the reality was the pandemic lasted far longer than we had originally anticipated. The effect of the pandemic persisting for longer than this time on our preparedness for the Covid-19 pandemic was that it required the Welsh Government to learn rapidly from its experiences to adapt and to improve its response. Our structures and response were not static and the HSSG structure, role and functions were continually evolving throughout the specified period to accommodate the new Covid-19 specific areas of work. A number of new sub-teams were created within divisions and personnel re-deployed both within the HSSG and from other Welsh Government directorates.

54. The CSA for Health is a member of the HSSG and attended SAGE meetings on behalf of the Welsh Government and I refer to his module 2B statement for detail of the SAGE discussions.

55. As the pandemic emerged in January and February of 2020, the Welsh Government response was initially managed by the Minister for Health and Social Services who was supported by officials from the HSSG with responsibility for emergency health planning, working closely with Public Health Wales.

56. Organograms representing the organisational structure at significant points within the pandemic period are provided as Exhibits to this statement.

    i. **AGM2BHSSG01/7-INQ000083227**, dated November 2019, sets out the structure as at November 2019 represents in advance of the pandemic.

ii. **AGM2BHSSG01/8-INQ000083228**, dated January 2021, and **AGM2BHSSG01/9-INQ000083229**, dated June 2021 – shows the structural changes which took account of the pandemic – including the introduction of the role of Deputy Director General for Health and Social Services Group, Head of HSSG, and Director of Vaccines. This also sets out the role of Reg Kilpatrick who was Director General of Covid-19 Coordination and Director of Local Government with responsibility for the Covid-19 project team. Although not set out, in this period Jo-anne Daniels also transitioned to being Director for Test, Trace, Protect.

iii. **AGM2BHSSG01/10-INQ000083230**, dated May 2022, highlights the change of Permanent Secretary to me from November 2021 and the resulting change of the Director General of the HSSG to Judith Paget in November 2021.

57. HSSG officials at Director level are outlined in the organograms for 2019 – 2021 however I have outlined below the key officials related to the Covid-19 response working within HSSG which included:

i. Myself, in my previous role as Director General, Department of Health and Social Services; and Chief Executive NHS Wales until November 2021 when I was appointed to my current role.

ii. Simon Dean, Deputy Chief Executive of NHS Wales. Prior to the start of the pandemic Simon had been seconded to Betsi Cadwaladr University Health Board to provide additional support and leadership. During phase 1 of the pandemic, as outlined below, Alex Howells was seconded to the role of Deputy Chief Executive NHS Wales to help group conversations with the NHS and stakeholders and to act as a bridge alongside me to the NHS. Simon later returned to post and alongside assisting my oversight of the NHS, also led on PPE and the NHS and social care recovery framework.

iii. Frank Atherton, Chief Medical Officer and Director of Population Health Directorate.

iv. Chris Jones, Deputy Chief Medical Officer.

v. Gill Richardson, seconded from Public Health Wales initially as Senior Professional Advisor to the Chief Medical Officer and then later took up the

post of Vaccine Programme Director and as an additional Deputy Chief Medical Officer.

vi. Rob Orford, Chief Scientific Adviser for Health, and Chair of the Technical Advisory Group.

vii. Fliss Bennee, Co-chair of the Technical Advisory Group.

viii. Joanna Jordan, Head of HSSG.

ix. Jean White, Chief Nursing Officer until April 2021 at which time Gareth Howell temporarily held the post pending Sue Tranka taking up the role in August 2021.

x. Andrew Evans, Chief Pharmaceutical Officer.

xi. Albert Heaney, who was Director of Social Services and Integration until March 2020 before becoming Deputy Director General and Social Services & Integration until June 2021. Since June 2021 Albert has been the Chief Social Care Officer for Wales.

xii. Samia Edmonds (also referred to as Samia Saeed-Edmonds), NHS Planning Director, and Chair of Health and Social Services Covid-19 Planning and Response Group.

xiii. Jo-Anne Daniels, Director of Mental Health, Vulnerable Groups and NHS Governance was the lead Director for Test, Trace and Protect from April/ May 2020.

xiv. Alan Brace, Finance Director.

xv. Steve Elliot, HSSG Director of Finance.

xvi. Andrew Sallows, Delivery Programme Director for the NHS.

xvii. Claire Rowlands, Interim Director of Vaccines.

58. This is not an exhaustive list and the HSSG however I exhibit as **AGM2BHSSG01/11-INQ000177492** (dated 20 February 2023) a PowerPoint document which shows the membership of the Executive Directors Team within the HSSG as of January 2020,

January 2021, January 2022 and February 2023. Please note there is a typo in the document as Samia Edmonds joined the Executive Directors Team in February 2020.

59. The HSSG worked closely with a number of other directorates throughout the pandemic period and particularly with the Covid-19 project team led by Reg Kilpatrick to support the provision of advice to Ministers on a range of issues relating to the functions HSSG oversaw, including on NPIs.

60. In addition to the key officials in HSSG outlined above, we also introduced Senior Military Liaison Officers into the HSSG to assist with NHS planning, and who were ultimately distributed across the NHS in Wales in support roles ranging from planning to field hospital establishment and the operation of vaccination centres. This was delivered through a mix of discretionary support discharged through Military Aid to Civil Authorities ("MACA") arrangements. The Military involvement started very early in in our planning and preparation phase and acted as planning support, logistics advice, operational support for establishment and a reference point for capacity planning and urgent actions and were very welcome as part of the broader HSSG and NHS team.

61. The Inquiry has asked how the HSSG dealt with (to the extent that it arose) conflicting internal opinions. The Inquiry also asks whether HSSG spoke with one voice to the Welsh Government or external bodies and whether there were examples of conflicting views in relation to significant issues about the response to Covid-19. As outlined in paragraph 48 of this statement, the HSSG consists of several policy divisions and covers two distinct sectors – health and social services. It is a large directorate within the Welsh Government. The HSSG did not give advice as a whole – officials would provide advice to Ministers on their area of policy responsibility. The HSSG in so far as it had "a voice" would have been my voice, as Director General HSS and later Judith Paget's voice.

62. In respect of the NHS, the very regular contact, co-design and access to expertise from the NHS meant that advice and assessment was consistent with the NHS tone and voice and I hope represent a collective, rather than individual view. However, I was content through my leadership role and experience that I could advise and respond personally also. It is worth noting that alongside a pattern of general updates on the NHS position, Cabinet received an NHS status position which had been shared and confirmed with NHS Wales Chief Executives prior to meetings so I knew it reflected a collective position.

63. I am not aware of any conflicting internal opinions but do not doubt that there would have been parts of the HSSG or NHS with different views or priorities, particularly. given the structures we had in place and the variety of representatives involved in co-production of policies and advice, for example in our planning and response arrangements. However, this did not prevent agreement or consensus to emerge, and I am not aware of any significant issues with conflicting views that arose about the response to Covid-19. There was an open environment for opinions and views to be shared, and from different perspectives, that was just a normal part of our approach. The NHS was always supportive of timely national interventions that would act to mitigate Covid-19 demand and harm, rather than just expect the NHS to respond to the pressures that emerged; on occasion, the NHS may have preferred even earlier interventions in this respect, but rightly Ministers through Cabinet had to make broader judgements including other sector impacts, public engagement and funding.

The information and evidence available to the HSSG regarding the nature and spread of Covid-19 in Wales

64. The office of the CMO(W) provides independent professional advice and guidance to the Welsh Government's Cabinet, Minister for Health and Social Services and Deputy Minister for Health and Social Services and their officials on matters relating to health strategy, public health, quality and safety, R&D, and other relevant matters. As part of HSSG there was close working between the CMO(W) office and HSSG officials. Information from the CMO(W) office was freely available on an ad hoc basis via Microsoft Teams calls or emails. This ad hoc advice would not have been formally logged or recorded (other than in email correspondence) but would often entail asking the CMO's office to review MA's, correspondence to stakeholders, or lines for the Minister.The Allied Health Professionals and Healthcare Science Team (AHPST) within HSSG was previously led by Rob Orford, Chief Scientific Adviser for Wales Health acting as Deputy Director and traditionally provided scientific advice on a range of HSSG policy areas. Name Redacted joined the Welsh Government in October 2020 as Deputy Chief Scientific Adviser for Health. This was to cover Dr Orford's duties as Head of Profession for Healthcare Science whilst he was fully engaged in the Covid-19 response. When Rob Orford moved to focus on the Covid-19 response, Alex Slade, Deputy Director of Primary Care took over leadership of the Allied Health Professionals and Rehabilitation team. This team developed as a separate team and for part of the time worked on the initial Long Covid policy for Welsh Government.

65. I exhibit as **AGM2BHSSG01/12-INQ000282306** (dated 29 April 2022) a document which shows the team's make up throughout the pandemic period, including roles and responsibilities. The separation of the AHP and Rehabilitation team from the Healthcare Science Team is illustrated. To note is that the AHP and Rehabilitation team members continued with their usual roles in respect of providing advice on the skills and best 'use' of Allied Health Professionals (AHPs) in a wide range of services and settings throughout the NHS, social care, local authority, private practice, education, and the judicial system. AHPs is an umbrella term for 13 of the professions regulated by the Health and Care Professions Council, namely: art, music and drama therapists, podiatrists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists, orthotists, and speech and language therapists. I also exhibit as **AGM2BHSSG01/13-INQ000282307** (dated 1 April 2020) a document outlining the team structure and meeting schedule.

66. There was a recognition that additional rehabilitation services would be required for people who had been significantly affected by a Covid-19 infection. This was prior to a recognition of 'Long Covid' as a new syndrome / condition. The AHP and Rehabilitation team therefore worked to develop an all-Wales rehabilitation framework, which was later followed by the development of 'Long Covid' services, which utilised the framework. I exhibit the all-Wales rehabilitation framework (dated 22 May 2020) as **AGM2BHSSG01/14-INQ000282092**. This was updated in March 2021 and I exhibit this version as **AGM2BHSSG01/15-INQ000282305** (dated 24 March 2021). Rob Orford, and officials who formed part of the Healthcare Science team, moved to focus on Covid-19 work. Rob Orford became chair of the Technical Advisory Cell ("TAC") within the Welsh Government which provided advice to officials and Ministers. Rob Orford attended the UK Government's SAGE meetings and brought back the information to the CMO(W) and informed advice coming from TAC and from the wider Technical Advisory Group ("TAG") which he also chaired with Fliss Bennee, HSSG Deputy Director for Technology and Digital. TAG membership included a number of policy and scientific/technical leads from the HSSG. The TAC was accountable to the CMO(W) and also provided advice, risk assessment and planning assumptions to the Covid-19 Planning and Response Group and provided essential scientific and technical advice on the nature of the virus, epidemiology, transmission rates and modelling to inform HSSG policy.

67. The TAG was supported by a number of subgroups, each responsible for a specific focus area, including policy modelling; international research; socio-economic harms;

virology and testing; children and schools; risk communication and behavioural insights and environmental science. Each group is made up of external experts from academia, policy and a member(s) of TAC and proactively provided advice with regards to their individual areas. TAG publish their reports on different modelled scenarios to inform planning and decision-making.

68. From early April 2020, statisticians in the Welsh Government's Knowledge and Analytical Services ("Knowledge and Analytical Services") compiled a regular "data monitor". This was developed in recognition of the need for a single document containing a rounded view of data covering all aspects of the pandemic to support multiple audiences – such as myself, CMO(W) office, TAC, Ministers, and other senior policy officials. The monitor brought together the latest data on the pandemic and provided a concise and timely way to advise Ministers and senior officials on the latest figures and trends. The monitor drew on a wide range of the data sources set out in the earlier part of this statement and covered the following themes:

    i. Cases, deaths and vaccinations
    ii. Health and social care
    iii. Shielded and vulnerable people
    iv. Attitudes and behaviours
    v. Economy and labour market
    vi. Public services

69. The presentation of such information was broadly effective in terms of ensuring that the key data could be understood and gathered in one place. HSSG officials worked closely with Knowledge and Analytical Services throughout the pandemic period. Sometimes officials would invite Knowledge and Analytical Services to provide briefings on the data and statistical analysis as part of regular meetings policy officials had with Ministers, for example on Test Trace Protect or vaccinations. This provided opportunities for Ministers and officials to ask questions to ensure that the data was understood before recommendations made by officials or decisions made by Ministers. The Chief Statistician also met regularly with the CMO(W) to brief him on latest statistical developments.

70. Knowledge and Analytical Services was also essential for providing assurance around NHS management information on Covid-19 related activity which was published weekly and then daily during the specified period. This data was collected by Digital Health Care Wales ("DHCW") from health boards. Statisticians in Knowledge and Analytical Services worked with DHCW and HSSG officials to develop a good awareness of how the data was collected, including understanding the definitions and processes used, and how these compared to other parts of the UK. This information was important for informing Ministers on the current capacity of the NHS.

71. As well as formal data reporting and dashboards produced for Ministers within the HSSG we also had access to operational data and information which was essential to support decisions by or advice from myself, CMO(W), CNO(W), the wider HSSG and NHS leadership about the health care system in and to inform discussions, promote understanding, and to better direct capacity. This particularly helped in responding to more public discussions in press conferences and committees to provide clear tangible updates on the impact of Covid-19 which was more than statistical data and modelling projections. The use of this data in the health care context will be explored further in module 3 of the Inquiry.

72. Public Health Wales is the national public health agency in Wales and is one of the public bodies that form part of the Welsh NHS. One of its roles is to protect the public from infection and to provide advice on epidemiology, and it was involved in the early months of the pandemic. Public Health Wales supported the Welsh Government and CMO(W) in assessing progress, international understanding, and advice on the impact of the pandemic as it was emerging. Officials in HSSG worked closely with Public Health Wales on a number of Covid-19 workstreams with Public Health Wales supporting the policy development by providing advice and reviewing guidance. This included, for example, advice on testing, contact tracing and vaccination.

73. The Inquiry has asked whether Public Health Wales provided advice to the Welsh Government regarding the first lockdown (in particular during January to March 2020), and when the Welsh Government was considering easing NPIs (which led to the lifting of restrictions at the end of the first lockdown). As outlined below Public Health Wales provided initial support in January 2020 by attending the daily UK Incident Management Team ("IMT") meetings and by contributing to preparatory works being undertaken by the Welsh Government. We used Public Health Wales in respect of their core responsibilities and also their emergency response functions, and I was pleased that we had access to an expert national organisation that was able to respond, support

and engage with the national response and notably to act in support of the CMO(W) and Public Health Division. Their involvement in a range of our groups was a significant contribution to our plans and actions in Wales.

74. Public Health Wales did not provide advice on the first lockdown. In relation to the decisions regarding easing NPIs, Public Health Wales provided advice on the 'Public Health Protection Response Plan' which was commissioned by CMO(W). I exhibit this document as **AGM2BHSSG01/16-INQ000182417** (dated 5 May 2020). The plan outlined steps to put in place a contact tracing system and move towards lifting restrictions.

75. Between March and October 2020 (prior to the first formal advice note on 10 October 2020) Public Health Wales was engaged in a number of meetings and discussions across the HSSG in relation to infection prevention control, Test Trace Protect (Test Trace Protect) and discharge guidance. Public Health Wales officials and consultants were also members of various boards and groups established as part of the response arrangements including the Technical Advisory Group (TAG). HSSG did not keep a formal log of advice from Public Health Wales during this time as this was dispersed across the HSSG and programme boards and groups established as part of the response.

HSSG function, role and responsibility during the Covid-19 pandemic in respect of NPIs

76. During the course of the pandemic, I wrote four Accountable Officer letters to the Welsh Government's Permanent Secretary which set out what I saw as the key factors at the time which shaped and informed the Welsh Government's response. They were intended to act as a contemporaneous record and to allow for personal reflections and changes to take place; I also deliberately retained the format for consistency at the different phases to help track the environment and our response. These four letters are set out in exhibits **AGM2BHSSG01/17-INQ000083231** (dated 13 May 2020) **AGM2BHSSG01/18-INQ000083232** (dated 29 September 2020) **AGM2BHSSG01/19-INQ000083233** (26 March 2021) and **AGM2BHSSG01/20-INQ000083234** (dated 29 October 2021).

77. When I took up my current role of Permanent Secretary in November 2021, my successor to the Director General HSS role, Judith Paget, continued with the practice of chronicling and documenting the HSSG's response to the Covid-19 pandemic. Judith's letter is exhibited at **AGM2BHSSG01/21-INQ000083235** (dated 6 May 2022).

78. My four letters largely speak for themselves and reflect my assessment of the work of the HSSG at the time of writing through the phases of the pandemic. The contents of these letters speak to matters beyond the scope outlined by the Inquiry for Module 2B but illustrate the multifaceted nature of the HSSG. Set out below is additional context to my four letters, with a specific focus on the role of the HSSG in respect of key decisions and NPIs. I have set this out to reflect the phases outlined in my letters, however the detailed contents of the letters are not reiterated and should be considered alongside this statement.

79. During the specified period there was a tremendous level of activity within the HSSG, of which supporting decision-making in respect of the imposition or non-imposition of NPIs played a small part, primarily led by the CMO(W) and CSA for Health, both of whom were part of HSSG and will be providing separate evidence to the Inquiry.

80. Decisions were made by the Welsh Ministers. This was usually done in Cabinet but there may have been instances at the start of the pandemic for example when decisions would have been made by a smaller group.

81. In terms of decisions taken exclusively by the Minister for Health and Social Services, those that I and the HSSG would have been involved with would have related to the health and social care system. As outlined above and detailed further in this statement below, the HSSG had a role in support Ministers in the decision-making process and as such had a role in, gave advice on, and participated in broader discussions about the imposition or non-imposition of NPIs. There were instances where the Minister for Health and Social Services signed off the final legislative amendments to the restriction regulations but there was regular discussion between the Minister for Health and Social Services and First Minster throughout the period as well as regular Cabinet meetings. I understand that the Minister for Health and Social Services and colleagues dealing with the restriction regulations and 21-day reviews have provided evidence to the Inquiry and would be best placed to comment on whether the Minister for Health and Social Services made decisions relating to NPIs without the need for approval from the First Minister or the Cabinet.

82. The Inquiry has asked (regarding significant meetings with Ministers and senior Civil Servants) what the processes were for recording meetings, and whether the HSSG made its own record. It also asks whether the record would accurately record dissent or disagreement as between participants and / or civil servants, experts, or advisors. As already noted, as civil servants we have responsibilities to support Ministerial

decision making and that support provided without without fear or favour and in accordance with the Civil Service Code. Whilst verbatim notes of meetings were not taken these would reflect the mood and content of meetings and options and considerations which were presented to Ministers. The environment created by the First Minister at Cabinet allowed us to contribute personally and from different perspectives. We were not limited in our views so there was no need in advance to coordinate our response, although we all had access to the same sources of information and intelligence and our teams and officials were constantly engaging with each other.

83. In response I would say that in relation to Cabinet meetings (which are of course significant meetings involving ministers and senior civil servants) it is the Cabinet Secretariat, not HSSG, who take a record (being the minutes of Cabinet meetings). Minutes are typically agreed by Cabinet at the following Cabinet meeting. Whilst the Cabinet minutes (which have been provided to the Inquiry) are not a verbatim record of every word spoken, they do provide a detailed account of everything discussed, including where concerns and divergences of opinion are raised. Action points and outcomes are also provided in the minutes. To the best of my knowledge no documents such as emails, notes and WhatsApp messages are held by the HSSG recording such discussions.

84. The Inquiry also asks whether we discussed this with anyone else within the Welsh Government, or outside of the Welsh Government, and whether the recommendations were joint or individual recommendations. The recommendations were individual recommendations noting the perspective we were asked to present on but informed by and consistent with those working with us. For example, my NHS view was informed by my active and regular contact with the NHS organisations across Wales and health stakeholders. In relation to discussions within the Welsh Government or externally, the general approach at Cabinet meetings was for the CMO(W) to give advice which would be based on information from both Public Health Wales and TAC / TAG. The CSA for health would provide advice based upon TAC / TAG guidance and I would generally lead on summarising the pressures on the NHS.

85. In relation to less formal ministerial meetings (for example Cabinet pre-meetings, or brief meetings on topics of immediate interest, or when officials met with ministers to share information) there would be no formal notes or minutes for such meetings, as formal decisions were not being made. Ministers would typically follow the advice of officials, and it is unlikely there are any instances of ministers significantly deviating

from the advice provided by officials. Officials and Ministers worked closely together during the pandemic, which minimised the possibility of disagreement or the provision of inadequate advice and enabled decisions to be made efficiently. This open environment, and the interest in officials views to support the best decisions, remained a feature throughout. I and others felt permitted to say what needed to be said, not just what might be wanted.

86. The 21-day review cycle process included a visible NHS and social care commentary and assessment. While it was important the NHS and care system pressures were highlighted and considered alongside public health and other harm analysis, the arrangements put in place in phase 1 (January to March 2020) to assess NHS capacity and build resilience preceded the 21-day review process but were critical to the tone and direction of the response. The reasonable worst-case scenario identified health and care systems as at risk and we were seeing internationally that risk play out. HSSG acted rapidly to prepare the NHS and care sector for what was likely to be their greatest challenge, assessing capacity and resilience and taking mitigating action where needed to support the sector. That assessment was continued into phase 2 (May to September 2020) and onwards adapted for/fed into the 21-day review process, but it is important to highlight the work done in advance of and despite any national lockdown or NPIs.

87. The Inquiry has asked for an overview of how the reasonable worst-case scenario was determined, and to provide a summary of what data sources this was based upon. I am also asked to explain how often the reasonable worst-case scenario was reviewed, and to provide an overview of any limitations in how the reasonable worst-case scenario was calculated or modelled. I understand that Robert Orford, CSA for Health has provided written evidence to the Inquiry following requests for evidence covering the Technical Advisory Group (TAG) and the Technical Advisory Cell (TAC). He is best positioned to answer queries in relation to reasonable worst-case scenario and any limitations in modelling, but my understanding is that the reasonable worst-case scenario were reviewed periodically by the TAG modelling subgroup, and they would have considered the technical issues and limitations around how reasonable worst-case scenario was calculated or modelled.

88. While outlined below is the high-level summary of the NHS assessment which Ministers received to inform decision-making around NPIs there was tremendous efforts behind the scenes by the HSSG and wider NHS and care sector working to input into to modelling, contribute to planning, and collaborating on innovative solutions

to enable us to assess and protect the NHS during the pandemic. It will not be possible in this statement to outline the detail of all of those efforts, but I am extremely grateful and proud of all those who contributed. This enabled a shared understanding of pressures, trends and forecasts.

89. The Inquiry has asked the extent to which there was informal or private communication about significant decision-making, such as through WhatsApp groups (or other forms of group chats). To my knowledge WhatsApp messages or text messages were not used for significant decision-making within the HSSG. As an example, I personally had no WhatsApp group exchanges with any of my senior team in HSSG or with the NHS in Wales. Microsoft Teams and email were the main form of communication alongside using our existing governance mechanisms for Ministerial decisions and NHS system decisions and our reliance on the regular, active, sometimes daily contact with colleagues and NHS representatives. Whilst informal meetings with ministers would not necessarily have been recorded, all decisions made would have been recorded in the form of a Ministerial Advice and formal decision response or, for the case of NPIs and similar, in minutes of Cabinet papers. Despite the pandemic context and urgency, it was important that we used the normal, proper mechanisms available to us, although with increased frequency.

Phase 1 – January – 31 March 2020

90. The HSSG Public Health Division which came within the Population Health Directorate and under the leadership of Frank Atherton, CMO(W), naturally worked closely with the CMO(W) team and co-ordinated the initial 'containment phase' of the Covid-19 pandemic.

91. Early January 2020 when news of the situation in Wuhan began to emerge Public Health Wales were tasked with monitoring the situation and reporting into the HSSG Public Health Division. Public Health Wales is the national public health agency and its role is to protect the public from infection and to provide advice on epidemiology. Public Health Wales attended the daily UK Incident Management Team meetings (time limited team led by Public Health England to provide strategic direction and co-ordination between public health organisations) which started in January 2020 and reported back to HSSG Public Health Division.

92. After 24 January 2020 HSSG Public Health Division began to meet with Public Health Wales daily. The strategic aims of the daily meeting were as follows:

i. Monitor and assess the risk to public health in Wales (as part of the UK response);

ii. Facilitate detection, immediate case management and isolation to prevent transmission in Wales (as part of the UK Response);

iii. Develop a suitable diagnostic pathway for the novel strain;

iv. Provide robust guidance and information for health professionals and the public in Wales (as part of the UK response); and

v. Facilitate Public Health Wales and Welsh Government communications and actions (cross government, NHS and wider partners).

93. The work of the HSSG Public Health Division during these early stages, and in collaboration with Public Health Wales, included addressing issues such as port health, isolation facilities, development of testing facilities, development of High Consequence Infection Units ("HCIU") as well as keeping abreast with the current public health situation in Wales and the rest of the UK.

94. A daily rhythm of meetings was developed with the purpose of keeping up to date with developments and forward planning. The daily rhythm consisted of:

10.00hrs daily Public Health Wales attending UK Incident Management Team (5 nations meeting including Republic of Ireland)

12.30hrs daily CMO/UKG

13.00hrs daily Public Health Wales Incident Management Team

14.00hrs official release of UK figures (Department of Health and Social Care)

15.00hrs daily Public Health Wales/Welsh Government

16.00hrs daily communication call Public Health England/five nations.

95. This cycle of daily meetings helped informed the daily Novel Coronavirus updates to the Minister for Health and Social Services from the HSSG Public Health Division which started on 28 January 2020 and continued until 22 September 2020. The purpose of these updates was to provide an informal briefing to the Minister for Health and Social Services on the evolving public health incident around 15.00hrs each day

following the latest sit rep from the UK Government. This update would set out the UK CMOs' risk assessment for the UK, information on testing, key advice and messaging and an overview of any four-nation engagement. These briefings, while directed at the Minister for Health and Social Services from the HSSG Public Health Division were also circulated to all Ministers and key senior civil servants in Welsh Government.

96. In early February we received a commission from the UK Government to consider the legislative levers the Welsh Government might want now or in the peak of a reasonable worst-case scenario should it occur. The proposed legislative levers were to build upon the Four Nations Pandemic Influenza Bill that had been developed following exercise Cygnus in 2016. The devolved governments were asked to confirm if the provision in the draft Bill was appropriate for the current outbreak, if any of the previously discounted provisions were now required, or if there were any additional powers we may want. It was confirmed that the current requests for additional powers were themed around quarantine, police powers, passenger information, stopping flights and immigration. Within Welsh Government the HSSG Public Health Division acted as the central co-ordinating lead for the commission and for the subsequent work on the development of the Coronavirus Bill. Neil Surman, Deputy Director Public Health led on this work. Further information regarding the Coronavirus Bill and the legislative process involved leading up to it receiving Royal Assent on the 25 March 2020 is, I understand set out in the statement of Helen Lentle, Director of Legal Services referenced M2B-WG-01.

97. Alongside the work on the Coronavirus Bill, officials in the HSSG Public Health Division continued to explore with Public Health Wales the existing legislative levers available to respond to the virus ahead of any confirmed cases in Wales. In England, the Health Protection (Coronavirus) Regulations 2020 had been made on 10 February 2020. While the Minister for Health and Social Services did not consider equivalent regulations were, at that time, required for Wales it was recognised that clarity around the options for containing the virus were needed. Public Health Wales led on the creation of a 'Task and Finish Group' to develop a more expeditious process using the existing provision set out in the Health Protection (Part 2A Orders) (Wales) Regulations 2020 to legally mandate an individual to comply with clinical assessment, testing and or treatment where they refuse to do so. The group had representation from the Magistrates Service, local authorities, the police, WAST, Local Health Boards and Welsh Government. The purpose of the Group was to develop an expeditious end to end process for an application to a district judge (magistrates court) for a patient

considered to be at risk of a Coronavirus to be detained for quarantine, testing and if necessary treatment.

98. I established in February 2020, the HSSG Coronavirus Planning and Response Group ("Covid-19 Planning and Response Group") which was chaired by Samia Edmonds and vice-chaired by Gillian Richardson, Senior Professional Advisor to the CMO(W). This group reported to myself as Director General HSS and Frank Atherton, CMO(W), recognising the role of public health advisor Frank was playing during this period providing advice to Ministers and to the NHS.

99. The Covid-19 Planning and Response Group brought together strategic representatives of the HSSG, NHS Wales and social care. Its role was to consider the latest reasonable worst-case scenario for Covid-19 risk assessment, co-ordinate contingency response planning across HSSG, share information and communications to raise awareness on contingency arrangements and actions and provide a strategic interface for health, social care services and Welsh Government HSSG officials. **AGM2BHSSG01/22-INQ000083236** (dated May 2022) and **AGM2BHSSG01/23-INQ000083237** (dated 20 April 2020) outline the structure of the Covid-19 Planning and Response Group and its links to the wider organisation and externally.

100. The first meeting of the Covid-19 Planning and Response Group was held on 20 February 2020, eight days before the first Covid-19 case in Wales. Each of the Local Health Boards provided a key issues update for their area covering NHS and care services enabling HSSG officials to have a good understanding of preparedness, system risks and issues, which included discussion on PPE supplies and guidance preparation. The Covid-19 Planning and Response Group remained active throughout the whole of the specified period. It was a structure that provided a lot of valuable intelligence and as soon as significant risks emerged that required more dedicated input, I ensured that specific Cells were added on to the structure. It acted to share experiences and assessment in collaboration with the healthcare system and to ensure proposed actions were as informed as possible.

101. There were seven sub-groups of the Covid-19 Planning and Response Group established to co-ordinate action and manage systems risks across a number of areas. Similarly, these ensured a collaborative approach across Welsh Government and healthcare system representatives. The sub-groups covered the following areas:

   i. **Primary & Community Care**

The Co-Chairs of this group were NR Professional Medical Advisor, Primary Care and NR Nursing Officer, Primary and Community Care, Integration and Innovation.

The group co-ordinated Covid-19 planning and response across the primary and community care sectors, including for the reasonable worst-case scenario. The sub-group provided the point of contact and communications with those sectors during the Covid-19 pandemic. The sub-group's focus was to share national information, including latest risk assessment and advice; examine and seek to address sector concerns; clarify and set out key planning and response structures; identify appropriate contingency measures going forward; and advise on strategic operational response requirements.

ii. **Acute Secondary Care**

Co-Chairs of this group were Dr Chris Jones, Deputy Chief Medical Officer, Andrew Sallows, Delivery Programme Director and Steve Curry, Chief Operating officer, Cardiff and Vale University Health Board. The group provided leadership and oversight in relation to services normally provided in hospital settings. The aim of the group's work was to free up as much capacity as possible in hospitals for those patients most severely affected by Covid-19 as well as maintaining services for other people with life threatening conditions. The group supported the NHS in Wales in its preparations across a number of pathways, including consideration of whether and how certain patients could be managed at home, what criteria should be used to decide whether people should be admitted to hospital, and what treatment would be provided.

iii. **Social Care**

The Social Care subgroup was co-chaired by Albert Heaney, Director of Social Services and Integration and Andrea Street, Deputy Director Social Services and Integration and consisted of vital stakeholders from across the social care sector including Directors of Social Services, Welsh Local Government Association ("WLGA"), Social Care Wales ("SCW") and the Care Inspectorate Wales ("CIW"). The group also includes members that provide significant input from co-dependent areas such as housing, British Red Cross, Wales Council for Voluntary Action ("WCVA"), Care Forum Wales, and Community Health Council ("CHC"). The group was actively used as a networking platform to seek

views, test ideas and cascade of information between the sector and Welsh Government. During the first six months of the pandemic, these meetings were held approximately once per week. The group provided advice, guidance and leadership for all care settings in Wales and focused not only on short term immediate issues/actions in relation to the pandemic but also began to consider medium to long-term considerations (for example winter preparedness, consideration of future covid waves and efforts to return to a business as usual or covid stable position). The group focused upon registered care homes for adults and children; domiciliary care; supported living; learning disability 'shared lives' arrangements; personal assistants; and unpaid carers. The work of this group will be detailed further in the care sector module.

iv. **Workforce Deployment and Well-being**

Co-chairs of this group were Helen Arthur, Interim Director, workforce and organisational development and Julie Rogers, Deputy Chief Executive/Director of Workforce & OD, HEIW. This group focused on workforce modelling and wellbeing and also supported the Primary and Community Care Cell in relation to out of house services. The subgroup primary focus was to share national information with all key stakeholders; clarify and set out key planning and response structures; gather intelligence about workforce issues and examine and develop responses; identify appropriate contingency measures going forward; and advise on strategic operational response requirements.

v. **Digital Services**

Co-chairs of this group were Ifan Evans, Director, Technology, Digital and Transformation and Helen Thomas, Interim Chief Executive Officer, NHS Wales Informatics Service. This group fed into a number of the other sub-groups and shared knowledge and information of digital solutions to support what was a very different way of delivering services to the people of Wales and working. The pandemic brought into sharp focus the need to rapidly accelerate a number of digital programmes which had been scoped as part of the vision set out in A Healthier Wales, and the need for system-wide actions to take place in days and weeks that normally would have taken months or even years.

vi. **Health Countermeasures**

This group was chaired by David Goulding, Health Emergency Planning Adviser, and provided a link into the UK Countermeasures Network. The core members from Public Health Wales, NHS Wales Shared Services Partnership, the Social Services Integration Directorate (SSID) and the Health Emergency Planning Unit (HEPU). Finance Delivery Unit's staff were added to the Group, along with military liaison. The UK Countermeasures Network took forward procurements of supplies and worked on a four-nation basis to maintain essential supplies to the NHS and social care. The subgroup's focus was to access essential supplies and prioritise their deployment; ensure timely mechanisms were in place to deploy stock; monitor and respond to potential supply issues; manage the deployment of pandemic stock (and other stock, as appropriate); and work with the other UK countries and supplies network.

vii. **Essential Services (also referred to as Non-Covid-19 Services)**

This Group was co-chaired by Janet Davies, Deputy Director, Cwm Taf Morgannwg University Health Board Intervention Team and Mark Dickinson, Director, Clinical Networks, NHS Wales Health Collaborative. The Cell provided central leadership and oversight in relation to the maintenance and recovery planning for essential NHS Wales services not specified in the Covid-19 response. The aim of the group was to work within the World Health Organisation's operational guidance for maintaining essential health services during an outbreak to oversee and to ensure the identification and delivery of essential services to minimise avoidable mortality and significant morbidity from health conditions other than Covid-19. The group considered not only the identification of 'essential services' but also the advice around the delivery of services throughout the phases of the pandemic. The Group had strong links to the Primary and Community Care and Acute Secondary Care Cells which were primarily focused on the direct response to the pandemic.

102. This group and the seven subgroups which sat below it, demonstrates the recognition of the need for and the commitment to an integrated approach with the NHS, social care and government working together. This also importantly ensured that the focus was not just on hospital capacity when it came to planning and responding to the pandemic. Having dedicated groups considering the impact on essential services, social care, primary and community care and workforce well-being ensured that operational decisions, for example about hospital capacity, were not taken without considering the wider picture across the health and care system.

103. An HSSG Planning and Response Cell was also established consisting of a smaller group providing direct resource to support and help coordinate the Group. The Cell pulled in resources from across the HSSG as well as from the NHS Delivery Unit and WHSSC. This support also included a team of Senior Military Planners who were embedded into the Planning & Response Cell. Military Liaison Officers were also deployed to each of the seven local health boards, as well as WAST and Velindre NHS Trust. This team provided ongoing support, co-ordination and integration of the health and social services response and co-ordinated their work with the wider remit of the Welsh Government emergency co-ordination centre. This Cell included David Goulding, Welsh Government's Health Emergency Planning Adviser and built on the previous experience and relationship with NHS contingency leads and the strong emergency planning network in Wales.

104. In recognition of importance of and the scale of the demand for PPE, a PPE Supplies Cell established, headed up by Alan Brace, Director of Finance, and was directly accountable to me and to the Welsh Ministers with close links with NHS Wales Shared Services who provided PPE stock reports. This Cell was separate but provided regular updates (usually via weekly SitReps), to the Covid-19 Planning and Response Group.

105. Regular Covid-19 related 'Teleconference with Directors of Social Services' meetings were held by Albert Heaney as Director of Social Services with all Welsh Local Authority Directors of Social Services. These meetings were structured with set agendas where developments around emerging issues were discussed. Minutes were taken by officials in SSID. During the early stages of the pandemic these meetings were set up on a weekly to fortnightly basis. Agendas were set, with the primary function of the meetings being information sharing between officials and local authorities so that both could be kept fully informed of latest developments, upcoming issues and actions. Brief notes of key topics that were discussed and actions were taken for these meetings and retained centrally. Notable items that were on agendas for discussion at the time include: provision of PPE to social care providers; testing procedures at care homes; childcare for key workers; safeguarding; funding; and recovery.

106. As part of the HSSG Covid-19 structure another informal group was formed consisting of Frank Atherton, CMO(W); Jean White, the Chief Nursing Officer for Wales; Albert Heaney, the Director of Social Services; and Samia Edmonds, Chair of the Covid-19 Planning and Response Group; all of whom reported to myself as Director General of the HSSG. In terms of structure, this sat between the Minister for Health and Social

Services and the Covid-19 Planning and Response Group, but in practice it was simply a regular meeting and contact point at which myself and others responsible for key areas in the HSSG could share information. These meetings covered general updates and sharing of information from the various sub-groups, meetings and interactions we were all engaged in during this period to ensure a co-ordinated HSSG approach could be taken and that there was a shared level of understanding. Samia Edmonds, in her internal planning role, reported to me directly in my role of Chief Executive of NHS Wales and worked closely with Frank Atherton and Albert Heaney, noting their particular system responsibilities and Frank's specific role in oversight Covid-19 as CMO(W) and in his advisory role to Cabinet.

107. The Inquiry has asked for confirmation of the name of the group referred to above and to confirm whether the HSSG holds any documentation in respect of this groups' meetings. In relation to the group name, it did not have a formal title, but I exhibit as **AGM2BHSSG01/23-INQ000083237** (dated 20 April 2020) (see slide two) a structure chart showing the group (located between the Minister for Health and Social Services and the Covid-19 Planning and Response Group). These meetings were held to co-ordinate information from across the Health and Social Services Group. Regards documentation, as it was a relatively informal information sharing meeting formal notes and documentation were not produced. An informal summary or actions points were taken by my office but not for the purpose of recording discussions or circulation.

108. By choice, we enabled and welcomed views from the system routinely and at key moments, to ensure that the direction of travel on NPIs and on other system actions was supported by the NHS and stakeholders. It was important to ensure that the NHS voice, including in relation to NPIs, was available not just through my NHS Wales leadership role but always in line with the tone of the system and informed by the NHS assessment externally to the Welsh Government. This approach underpinned the reciprocal working used throughout the pandemic response, taking full advantage of the line management of the NHS and available expertise.

109. On 28 February 2020, the first confirmed Coronavirus case emerged in Wales. It was clear that there needed to be some administrative arrangements put in place to augment those already operating in the HSSG and in the Emergency Coordination Centre (Wales). These arrangements would be necessarily flexible to respond to the nature and scale of the pandemic, while also remaining proportionate to the challenge.

110. Changes were made to the HSSG Public Health Division by Frank Atherton, CMO(W) and Director of Population Health to ensure an effective response. These changes included Chrishan Kamalan being appointed as Acting Deputy Director with responsibility for co-ordinating the Welsh Government response to Covid-19. Neil Surman, Deputy Director of Public Health was tasked with continuing to oversee plans for new legislation and emergency powers to deal with the current outbreak if the need arises, but with some respite being provided by Chrishan Kamalan overseeing the internal requirements and support for health protection functions.

111. On the 3 March 2020 a joint action plan between the UK Government and devolved Governments in Wales, Scotland and Northern Ireland was published, 'Coronavirus action plan: a guide to what you can expect ("joint action plan") which is exhibited as **AGM2BHSSG01/24-INQ000182426**. In this plan it outlined that in order to ensure that health and social care systems were prepared to respond to all eventualities at all phases of the, at that time, potential pandemic, the NHS and local authorities have plans in place to ensure people receive the essential care and support they need, signalling that this may mean that other services are reduced temporarily.

112. Recognising the need to act quickly to prepare the sector, on the 5 March 2020 I wrote to the NHS Wales Chief Executives to outline the immediate actions I and colleagues in the HSSG would be taking to support the NHS, noting the need for regular communication. A copy of this letter, dated 5 March 2020, is provided in **AGM2BHSSG01/25-INQ000083238**. As well as the Covid-19 Planning and Response Group this included daily NHS Wales Chief Executives telephone calls to share information with NHS organisations and to take on any strategic issues. This daily call helped demonstrate visible leadership of our co-ordinated response across organisations and across Wales. My previous experience as a Chief Executive of a Local Health Board, along with my five years as Chief Executive NHS Wales, gave me valuable insight into the nature and scale of the risks that health boards would be facing in Wales and to enable protective/preventative measures to be put in place quickly. It also meant I had the relationships and credibility in place alongside the senior leadership of the NHS in Wales allowing for a pattern of rapid collaborative work that continued throughout the pandemic.

113. These meetings facilitated regular touch points with the service and have enabled the co-ordination and mobilisation of action, the identification and mitigation of risks, as well as regular and ongoing engagement and support. These meetings were also occasionally attended by the Minister for Health and Social Services and Deputy

Minister for Health and Social Services. The NHS and internal colleagues had been seeing the international images from Italy and other systems overwhelmed by the Covid admission numbers. It was clear from our assessment and NHS feedback that we needed to prepare and respond with urgency and at scale in order to protect the Welsh population and ensure the NHS was resilient.

114. Samia Edmonds, through her role as Chair of the Covid-19 Planning and Response Group, had responsibility, along with Andrew Sallows, for oversight of NHS capacity and demand. From early March 2020 they had been in regular contact with Local Health Boards to understand each health board area's respective position. Daily SitReps were put in place to establish capacity and occupancy.

115. In response to and in collaboration with the NHS Chief Executives, on 13 March 2020 the Minister for Health and Social Services and FM announced a framework of actions, within which Local Health Boards and social care providers could make decisions. This 'framework of actions' is the same as the 'joint ministerial actions' referred to in exhibit **AGM2BHSSG01/17-INQ000083231**, dated 13 May 2020. The framework enabled Local Health Boards, as part of their Covid-19 preparation, to:

i. Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised;

ii. Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery);

iii. Prioritise use of Non-Emergency Patient Transport Services to focus on hospital discharge and ambulance emergency response;

iv. Expedite discharge of vulnerable patients from acute and community hospitals;

v. Relax targets and monitoring arrangements across the health and care system;

vi. Minimise regulation requirements for health and care settings;

vii. Fast track placements to care homes by suspending the current protocol which gives the right to a choice of home;

viii. Permission to cancel internal and professional events, including study leave, to free up staff for preparations;

ix. Relax contract and monitoring arrangements for GPs and primary care practitioners; and

x. Suspend NHS emergency service and health volunteer support to mass gatherings and events.

116. These actions were in response to the public health emergency and noted that the overriding priority was to ensure health protection; the safeguarding of vulnerable groups; staff welfare; to ensure NHS and social care preparedness; and systems resilience. Samia Edmonds wrote out to the NHS Leaders on the 14 March 2020 confirming the agreement at the NHS national conference call and the Minister for Health and Social Services public statement on the 13 March 2020, reiterating that these actions were designed to protect our communities and allow for services and beds to be reallocated and for staff to be redeployed and retained in priority areas. A copy of this letter is exhibited in **AGM2BHSSG01/26-INQ000182429**. On 16 March 2020, in addition to the first ten actions already established within the framework, the additional national actions were recommended for local implementation by NHS Wales and social care providers including a refocus of Regional Partnership Boards to prioritise health and social care preparedness, in alignment with Local Resilience Forums. Further information on Local Resilience Forums is provided in my statement M2B-WG-01.

117. As the Covid-19 situation grew increasingly concerning, a statement was made on 17 March 2020 by the Minister for Health and Social Services confirming that the incidence or transmission of novel Coronavirus constituted a serious and imminent threat to public health. This statement was made for the purposes of putting in place the measures outlined in the Health Protection (Coronavirus) (Wales) Regulations 2020 ("Coronavirus Regulations"), which were considered an effective means of delaying or preventing further transmission of the virus in Wales and which came into force on 18 March 2020. Officials in the HSSG Public Health Division led on the policy development for the Coronavirus Regulations.

118. This preparatory work culminated and was formally reflected in the Covid-19 preparedness and response: guidance for the health and social care system in Wales ("2020 preparedness guidance") issued by Samia Edmonds, on the 18 March 2020 (**AGM2BHSSG01/27-INQ000182426**, dated 18 March 2020, refers). This document provided a framework for health and social services in Wales in responding to the outbreak of Covid-19. It outlined some of the roles and responsibilities of different

health care and social care agencies in Wales, while providing an overview of the whole system response at both national and local levels. It should be read in conjunction with other pre-pandemic guidance particularly the Wales Health and Social Care Influenza Pandemic Preparedness & Response Guidance 2014 (**AGM2BHSSG01/28-INQ000083240**, dated February 2014, refers). This initial systems risk framework issued on 18 March 2020 continued to be built upon throughout the pandemic period.

119. On 20 March, a TAC CMO(W) briefing note outlined significant risks to the NHS over the coming weeks and outlined steps needed to improve modelling data to assess continued risk (see **AGM2BHSSG01/29-INQ000083241**, dated 20 March 2020). Steps to maximise NHS capacity were driven with urgency due to the reasonable worst-case scenario assumptions that showed unprecedented numbers of potential deaths, hospital cases and community cases. Work was undertaken at the end of March 2020 to maximise the number of ventilated beds that could be provided in Wales, including the purchase of over 600 additional ventilators, opening parts of the new Grange University Hospital near Cwmbran, in South Wales, to provide an additional 350 hospital beds by the end of April, authorising a significant push of PPE to the seven health boards, the Welsh Ambulance Service Trust, Velindre and social care providers and offering final year medical students, student nurses and student social workers the opportunity to take on temporary fully paid roles.

120. One issue in early March 2020 was that we did not have accurate data sets from health boards that described ICU and hospitalisations from Covid-19. Prior to the pandemic we received data at a national level to include monthly acute bed and daily for critical care bed information. However, the existing information was insufficient for the requirements of pandemic management, the reasons for this included:

i. this information was not real time, and as such did not keep up with a very dynamic position regarding hospitals' capacity for Covid-19 patients;

ii. there were more admissions than death or discharges in the early stages of the pandemic;

iii. many beds could not be used for the treatment of Covid-19 patients due to equipment (largely respirators), environment (infection control), staffing issues or non Covid-19 patients in beds;

iv. 'surge' capacity was created, and changed daily, either by opening beds or changing their category e.g., from an acute bed to a critical care bed; and

v. Identifying Covid-19 patients was difficult and needed test or agreed criteria for consistency.

121. So, at the outbreak of the pandemic in March 2020 there was no system that captured a real time (daily) national picture of total beds and occupancy, identifying a particular condition was and added dimension of complexity that needed to be factored in. Having said that was the picture at a national level there were local systems to capture capacity and occupancy. However, these were inconsistent and varied in ambition, accuracy and output.

122. Initially this data was collected by phoning individual health board ICUs. The number of people in hospital was one of the measures that was used to understand and model whether the measures that were in place are slowing down the transmission of the virus. The TAC recommend that daily reporting was putting in place and work was undertaken to ensure that health boards were reporting using the same criteria (for example, clarifying reporting for Covid-19, recovering Covid-19 and non-Covid-19 patients).

123. It quickly became obvious the information and technology needed to produce models and scenarios necessary for scientific advice were not available within TAC. Requests for support to develop the tools and datasets we needed at pace were similarly unable to be met by Welsh Government Knowledge and Analytical Services (Knowledge and Analytical Services) or digital specialists, nor the NHS Wales digital specialists, known as NHS Wales Informatics Service (NWIS) at the time. Using the UK Government Digital Marketplace framework, a small external organisation called Armakuni was brought in to support TAC in developing the required data feeds and models. As Armakuni were already engaged with the NHS Wales Information Service and had clearance to work with Welsh data they presented as a sensible partner who could turnaround a dashboard swiftly.

124. From Monday 9 November 2020, to improve transparency and ensure data is available in a timely and accessible manner, data on the numbers on Covid-19 related NHS beds, admissions and hospitalisations on a daily basis (Monday to Friday) were published at 12pm via StatsWales.

125. Another dataset requested by TAC in March to improve modelling was mobility data in order to understand migration patterns to or within Wales. This data was obtained and provided to TAC in April and included in a modelling update, exhibited as **AGM2BHSSG01/30-INQ000066276** (dated 7 May 2020).

126. Work on scoping sites and operational requirements for field hospitals also commenced end of March 2020 with Cardiff and Vale University Health Board setting out the option to establish a field hospital for between 600 and 2000 beds at the Principality Stadium in Cardiff. Further information on bed capacity and the use of field hospitals is covered in Module 3. Welsh Government Local Government officials, working with HSSG, also started to look at options to increase mortuary capacity.

127. Importantly, at the end of March 2020, HSSG officials had Ministerial agreement to the National Covid-19 Testing Plan developed under the direction of Rob Orford and with input from with a range of stakeholders and experts. This was the start of the Test Trace Protect programme in Wales, **AGM2BHSSG01/31-INQ000083242**, dated April 2020, refers. The Testing Plan set out a phased and scaled approach to Covid-19 testing and with two prime objectives - reducing harm from Covid-19 (direct and indirect) and enabling the release from behaviour and social interventions.

128. Alongside this activity officials across Welsh Government were working, with HSSG Public Health Division leading and co-ordinating action, the Coronavirus Bill. The Coronavirus Regulations were intended to be a 'stop gap' pending the coming into force of the Coronavirus Act 2020 ("the 2020 Act") which received Royal Assent on 25 March 2020, shortly after Wales and the rest of the UK went into 'lockdown'. While the 2020 Act revoked the Coronavirus Regulations, they were replaced by the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 ("the Regulations") made on 26 March 2020[9]. The legal powers under which the Regulations were made relied on the powers being exercised in the event of or in response to a threat to public health and as such there needed be a continuous assessment of the public health situation. The Regulations additionally required a formal review every 21 days to assess the proportionality of the restrictions taking account of the public health situation in Wales.

129. Although the Regulations were frequently amended and subsequently replaced by multiple iterations, the 21-day formal review obligation continued until the expiration of

[9] Regulations revoked by Schedule 21 paragraph 68 Schedule 21 paragraph 68 of the Coronavirus Act 2020 (c. 7)

all Covid restrictions on 30 May 2022. Further information on the review process is set out in my statement reference M2B-WG-01.

130. While we were still developing our knowledge and understanding of the Covid-19 pandemic during phase 1, what was increasing clear was that any decisions around control measures in Wales required clear understanding of the NHS capacity, the availability of testing services and management of PPE supplies, all of which the HSSG had responsibility for. The work done by the HSSG to rapidly set up reporting lines and SitRep reports from the NHS meant that once the 21-day review cycle started the HSSG were well placed to provide the required assessment of NHS capacity and resilience to inform decision-making by Ministers.

Phase 2 – 1 April 2020 to 30 September 2020

131. The requirement to undertake a regular review in line with the Regulations was addressed through a process developed by the Welsh Government. Responsibility for managing the process rested with the Covid-19 Project Team which was established in March 2020. Reg Kilpatrick, who was a Director at the time of his appointment but was subsequently appointed as Director General, Covid Recovery and Local Government, led this team. Further information about the Covid-19 project team is provided in my statement reference M2B-WG-01.

132. While the responsibility for management of the 21-day review process sat with the Covid-19 Project Team, members of the HSSG, particularly the CMO(W) and CSA for Health and their teams were very much part of the review process providing professional advice on issues such as the various aspects of and options, for example lockdowns, face coverings and contact tracing. As noted in the preface to this statement, both the CMO(W) and CSA for Health will speak to their own roles in the decision-making process. In terms of myself and the HSSG we had a particular role in the 21-day review process in providing an overview of the pressures on the NHS and the capacity of the NHS to address what impact any recommendations for the imposition or non-imposition of NPIs would have on the NHS in Wales. The overview was provided through my attendance at 21-day reviews where I provided Cabinet with an outline of NHS capacity, which was a clear factor in decision-making.

133. The Inquiry has asked for an explanation as to how, if at all, divergent opinions regarding the imposition, non-imposition, extension or end of NPIs amongst the members of the HSSG or the Covid-19 Project Team would be reflected in

communication of advice or information to the Minister for Health and Social Services or other Ministers in the Welsh Government. As outlined earlier in this statement officials in the HSSG and Covid-19 Project Team provided support to Ministers without fear or favour giving the Welsh Ministers the best available information to decide, that may include some differences in the analysis and to offer views that differed across different sectors.

134. Reg Kilpatrick (Director General, Covid Recovery and Local Government) established the Covid-19 Project Team and I understand he is to provide written evidence to the Inquiry which will provide more detailed information in relation to that team. In relation to divergences of opinion Reg Kilpatrick and other members of the team, such as Thomas Smithson (appointed as interim Deputy Director for Restart during the pandemic) are better placed to provide comment on this as HSSG were a single contributor to the advice and information which the Covid-19 Project Team were coordinating and subsequently communicating to the Minister for Health and Social Services and other ministers. I understand that Reg Kilpatrick was closely involved in almost all the 21-Day Reviews, and is likely to have knowledge of the wide range of discussions that preceded and supported Cabinet papers and final Ministerial Advices, in addition to the evaluation of the impact of the measures that were put in place.

135. I understand that Thomas Smithson has provided a written statement to the Inquiry providing detail in regard to the role and function of the Covid-19 Project Team and his personal role in preparing for, and carrying out, the 21-day reviews. This included preparing the draft advice for ministers that formed the basis of the reviews, the content of which was used to prepare Cabinet Papers and formal Ministerial Advice submissions.

136. Early April 2020 WHSSC, supported by NHS Wales Shared Services Partnership and HSSG officials in the NHS Delivery and Performance Division, negotiated at pace arrangements for additional capacity from independent providers. The Minister for Health and Social Services had agreed at the end of March 2020 for the NHS to progress plans to procure extra capacity from the independent healthcare sector. This included the approval of the sum of up to £30m funding towards the costs of commissioning additional capacity. To facilitate these agreements HSSG officials worked with the UK Government to ensure that necessary relaxations to the Competition Act 1998 were provided for to ensure arrangements could be put in place quickly. The initial arrangements with private providers were put in place for 14 weeks, up to 5 July 2020.

137.The first 21-day review took place on 16 April 2020. At that time, it was too early for the HSSG to assess the impact the national lockdown had had on NHS capacity.

138.On 22 April 2020 the CMO(W) wrote to Public Health Wales to outline what support Welsh Government would require from Public Health Wales to support decision-making following the First Minister's comments in the Senedd which outlined tests for what would inform the lifting of restrictions in Wales. Public Health Wales were asked to provide firstly, a plan for the operational model for health protection in Wales; secondly a surveillance plan, which would include how to monitor the spread of Covid-19 in the NHS and the community in Wales as well as plans on how surveillance could be used to provide real time data on NHS capacity; and thirdly a plan for learning from international experience.

139.On 24 April 2020, the Welsh Government published 'Leading Wales out of the Coronavirus pandemic; a framework for recovery' ("the framework") **AGM2BHSSG01/1-INQ000083221**, dated 24 April 2020, refers. The framework described the Welsh Government's intended approach to leading Wales out of the pandemic, in a way that sought to keep everyone safe and in a manner that would revitalise the economy. The framework is outlined in my statement referenced M2B-WG-01. The HSSG, like the other directorates in Welsh Government contributed to the meeting the aims and objectives set out in the framework particularly in providing surveillance data and information from stakeholder engagement for the assessment of the four harms of Covid-19. Following the publication of the framework in April 2020, the Welsh Government developed a decision-making process in respect of Covid-19 lockdown review. This formed the basis of the 21-day review managed by the Covid-19 Project Team, **AGM2BHSSG01/32-INQ000066074** (undated) refers.

140.The review framework set five stages for decision-making and implementation in respect of NPIs which were:

Stage 1: Assessment of pre-conditions

Stage 2: Assessment of Balance of Harms

Stage 3: Assessment of specific measures or restrictions

Stage 4: Monitoring, with reinstatement if thresholds are breached

Stage 5: Evaluation of impact of easements / restrictions

141. Stage 1 included assessment of whether the capacity of the health system was sufficient to have headroom within which subsequent increases could be managed, alongside non-Covid health functions. As outlined above, NHS capacity monitoring was already taking place. It was recognised this will also need to consider the three epidemics (hospital, care homes and community). In May 2020 a Nosocomial Transmission Group was established, jointly chaired by Chief Nursing Officer and Deputy Chief Medical Officer, to provide more targeted advice. While the term "nosocomial" usually refers to hospital acquired disease, the Nosocomial Transmission Group agreed that this should be expanded to include any closed environment - such as care homes and residential centres. The purpose of the Nosocomial Transmission Group was to provide advice, guidance and leadership for all healthcare and care settings including hospitals, primary and community care, registered care homes, domiciliary care, learning disability units and prisons (healthcare settings) to minimise nosocomial transmission and enable the safe resumption of services. The Nosocomial Transmission Group was accountable to the Essential Services subgroup which was part of the Covid-19 Planning and Response Group structure and guidance and advice produced by the group would be considered by the Essential Services Group and then shared with the NHS, social care providers and local authorities.

142. Stage 1 also included assessment of the Test Trace Protect capacity to identify and contain new cases and assessment of whether the supply of PPE was sufficient to manage a subsequent increase alongside plans for supporting recovery.

143. Additionally, assessment of the Stage 2 balance of harms included assessment of the indirect harm caused if services including the NHS became overwhelmed due to any sudden large spike in demand from patients with Covid-19 on hospitals, critical care facilities and other key services (harm 2) and indirect harms from non-Covid-19 illness, for example if individuals did not seek medical attention for their illness early and their condition worsened, or more broadly from the necessary changes in NHS service delivery made during the pandemic in Wales to pause non-essential activity (harm 3).

144. It was essential to provide as part of this review process, a current and prospective view of NHS resilience and response. I would provide to the Minister for Health and Social Services, key officials and Special Advisers (for the Minister for Health and Social Services and other ministers as well) a daily update on the NHS. This was professionally supported by Andrew Sallows and Samia Edmonds in their respective operational and planning roles. In this I would provide a summary of the mood and view of the NHS more widely based on my discussions with NHS leaders and my tone

and language helped to track the concerns and status of the NHS using summary operational or statistical data. Both TAC and Public Health Wales provided regular updates to the Covid-19 Planning and Response Group meeting, TAC on the current reasonable worst-case scenario and Public Health Wales on the operational situation. Andrew Sallows received the operational data from Local Health Boards on capacity and occupancy which he would triangulate with updates from TAC and Public Health Wales and validate to form the assessment of NHS capacity which would be provided to the Covid-19 project team. This assessment of NHS capacity and resilience served the purpose of informing the 21-day review, but the original intent was to enable Samia Edmonds, in her planning role, to consider with HSSG colleagues the available means of increasing that capacity and mitigating against the impact of Covid-19 which during phase 2 included expanding field hospital capacity, relaxing DBS requirements for the independent sector, and developing methodology for allocation of critical care and other medicines.

145. The next 21-day review was on 7 May 2020 and the HSSG contributed to the review of lockdown advice prepared by the Covid-19 project team. The Health Delivery and Performance Division had started work with TAC to develop early warning indicators to inform when NHS capacity was at risk of over being overwhelmed to inform when non-essential, non-Covid-19 activity would need to be stepped down and Covid-19 capacity increased. These indicators while not finalised for the 7 May 2020 review, would provide a basis for advice in subsequent reviews. In the case of the Social Services and Integration Directorate specific advice was provided on the developing understanding of Covid-19 rates and surge capacity in social care, work on modelling need for PPE in social care and the implications of moving towards more face-to-face social services interventions such as safeguarding visits.

146. Alongside the 21-day review process, updating relevant Welsh Government Covid-19 Guidance, published on www.gov.wales was the responsibility of the HSSG. Typically, the HSSG would work alongside the Covid-19 Project Team, closely monitoring the advice coming from the CMO(W), TAC and Public Health Wales, to anticipate what the recommendations, and therefore updates to guidance, would be for each 21-day review. HSSG would, where possible, discuss amendments with stakeholders either in advance or immediately after decisions were taken and check the Welsh Government guidance for consistency and clarity of messaging. For example, if the decision related to changes to self-isolation policy, officials in HSSG would work with Public Health Wales on the scripts used by local and regional contact tracing teams

and notify them of those changes to ensure that the advice given to the public was correct.

147.The process of anticipating potential changes at the review points had to start early, almost as soon as each 21-day cycle ended, to ensure that we could issue the Welsh language version as soon as possible.

148.While this was the process adopted for updating the guidance in response to the 21-day reviews there were occasions where the HSSG updated the guidance between reviews due to the fast-moving environment or the emergence of new knowledge or evidence. An example of this was when the legal requirement to self-isolate changed from 10 days to 7 days. On other occasions the HSSG would provide advice to Ministers recommending the Office of Legislative Counsel ("OLC") be instructed to amend the Regulations to accommodate policy workstreams which had been developed. An example of this was following the introduction of workplace testing scheme which required an exemption to the isolation requirement in the Regulations to be provided for.

149.The creation of the central Covid-19 project team freed some capacity in the HSSG to focus on wider NHS and social care sector issues, with input from the Covid-19 Planning and Response Group. I will not outline the wider work of the HSSG, much of which will be the focus of later modules to the Inquiry, however, relevant to the management of NHS capacity, the Covid-19 Planning and Response Group continued to meet regularly during phase 2 and provide critical briefing and communication mechanisms across HSSG, NHS Wales and social care. Some of the initial additional support that had been drafted in during phase 1 returned to the NHS Wales Delivery Unit however the Senior Military Liaison support continued, albeit scaled back.

150.The HSSG enabled the NHS Governance structure to support new ways of working during the pandemic. Quarterly planning frameworks were introduced in May 2020 to provide assurance across the system. The impact of Covid-19 in March 2020 meant that the Integrated Medium Term Planning process was formally paused considering the emerging public health emergency. Quarterly operational plans were instead introduced as an interim measure for 2020-21 and a series of Operating Frameworks were issued during the year. The HSSG were responsible for reviewing the operational plans and providing feedback to the organisations and updating myself and the Minister for Health and Social Services on the key issues and themes emerging from the plans and any system requirement to address them.

151. The framework enabled even further the HSSG systems focus on a continued effective response to Covid-19, whilst providing other essential services in a careful and balanced manner. In issuing this to the NHS bodies I took advice from professional colleagues, including NHS Chief Executives and Medical Directors and broader clinical representatives. This advice showed a consensus across the health and care system that we must ensure delivery of essential services for our population and where possible recommence more routine care across all our healthcare settings.

152. Work on the Test Trace Protect continued at pace during this phase and testing was a clear priority for Ministers. I asked Jo-Anne Daniels, as an experienced Senior Civil Servant and director, to lead a 'Testing Cell' to bring together testing, contact tracing and surveillance. Agreements with the UK Government were put in place for use of the NHSX tracking app and development of a public test booking portal, cumulating in the publication on 13 May 2020 of 'Test, Trace, Protect'. The HSSG was engaged in successfully bringing together different parts of the Welsh public sector, and other agencies, to rapidly build a system of testing and contact tracing largely from scratch and on an unprecedented scale. Test Trace Protect was on the frontline of the Welsh Government's approach to limiting the spread of Covid-19 and managing any further surge of Covid-19 to protect the NHS from becoming overwhelmed. While Covid-19 testing and contract tracing will be subject to more detailed consideration by the Inquiry in later modules, Test Trace Protect was a critical part of the Welsh Government Covid-19 response to reduce the spread of transmission and provided essential data to inform decisions around NPIs, thereby reducing the need for restrictions on people's lives. The Test Trace Protect programme was developed rapidly from scratch with significant work put into collaboration with other organisations to deliver an outstanding service.

153. The third 21-day review was on 27 May 2020. Again, the HSSG worked with the Covid-19 project team to contribute to the advice for Cabinet. At this time capacity in the NHS and the availability of PPE was continuing to improve and did not represent a major constraint on some form of limited easement.

154. The fourth 21-day review was on 17 June 2020. By this this time Test Trace Protect was further established and population-wide contract tracing had begun as planned on 1 June 2020. This provided valuable data on the spread of Covid-19 and to help modelling predictions. Concerns regarding the trend and reluctance of the wider public to access health services were noted. The HSSG had worked with the NHS to ensure that health services remained flexible, responsive and proportionate: balanced against the risk of increasing transmission rates by expanding services too quickly or without

the proper countermeasures in place. The work of the Covid-19 Planning and Response, Essential Services Cell was critical to assessing this. A communications campaign launched in May had highlighted that services were open, and this was continued in June with a focus on cancer and related services. Quarter 2 of the NHS operating framework had been prepared and was issued on 18 June 2020, outlined future Covid-19 demand and ensuring contingencies in place to meet this and the provision of essential services.

155. On 22 June 2020 I wrote again to Local Health Boards to outline the national Covid-19 capacity planning assumptions, following on from my letter in April, to frame and facilitate their local decision-making on capacity and contingency requirements in terms of what were the second peak requirements. It had been hoped that the NPIs in place, as well as the option to reinstate lockdown, would negate the need for this contingency, but there remained uncertainties about the progression of Covid-19, the implications of winter, and the flu season.

156. The Nosocomial Transmission Group developed guidance in June 2020 on the impact of nosocomial transmission in hospital settings which I wrote out to health boards about in June 2020. The Nosocomial Transmission Group also worked closely with social care stakeholders around guidance and advice on infection control prevention. A subgroup of the Nosocomial Transmission Group was formed which focussed on infection prevention control, chaired by the Director of Nursing at Hywel Dda University Health Board and comprised representation from health and social care organisations as well as Health Education and Improvement Wales.

157. The fifth 21-day review took place on 7 July 2020. On this occasion, I attended the Cabinet meeting (by video link) and continued to attend 21-day reviews from this date where possible. The CMO(W) provided the overview of the public health situation outlining that in broad terms the situation was stable and improving so there was headroom to ease some restrictions in Wales, but each sector would need to take guidance into account. This assessment of headroom was based on the key indicators data which outlined the Covid-19 hospital admissions, daily case rate and bed occupancy figures to provide an overview of the position in the NHS. The work of HSSG officials along with Public Health Wales and Knowledge and Analytical Services was essential to bringing this key indicator detail to Ministers.

158. On 15 July a Testing Strategy for Wales was published setting out the testing priorities for the rest of the year (see **AGM2BHSSG01/33-INQ000083244,** dated 15 July 2020).

At this time the reasonable worst-case scenario was estimating some 20,000 tests a day may be required to contain the spread of the virus through effective contact tracing and to respond rapidly to local outbreaks. While the UK lighthouse laboratories were being utilised under the UK Testing Programme we also recognised the need to supplement this with capacity withing our own NHS systems. HSSG officials worked with Public Health Wales and Local Health Boards to plan for sufficient capacity in NHS Wales laboratories to support Test Trace Protect.

159.On 28 July 2020 I attended Cabinet for the 21-day review. Cabinet had been provided with the key indicator information on the current public health situation, which included the current 'R' rate, hospital admissions and bed capacity. This information was provided to Cabinet through Cabinet Papers, which I exhibit as **AGM2BHSSG01/34-INQ000048859**, dated 27 July 2020. The CMO(W) confirmed circumstances remained favourable for further restrictions to be lifted. I exhibit as **AGM2BHSSG01/35-INQ000048857** (dated 28 July 2020) the minutes of that Cabinet meeting.

160.Leading up to and during July, HSSG officials had been involved in a wide range of activities to maintain resilience in NHS services. This also included consideration of the impact on social care services in Wales. The Covid-19 Planning and Response Group had a dedicated Social Services Cell and regular engagement with the sector was in place via Albert Heaney. Our leadership over the social care sector was very different. In Wales over 90 per cent of social care providers for adults were in the private sector, the vast majority being small and medium size enterprises. Within the HSSG we were conscious that in normal times the ongoing viability of this sector was critical to hospital capacity and flexibility. It was therefore critical that during Covid-19 period we maintained close liaison with the sector.

161.During the summer and leading into autumn HSSG officials started to prepare for the possibility of a Covid-19 vaccine. Discussions between the four nations commenced on arrangements for purchase of Covid-19 vaccines and antivirals on a four nations basis. Officials also began work to ramp up the flu vaccination programme and explore options to expand this when a Covid-19 vaccine became available.

162.While at the next 21-day review, 18 August 2020, based on the key indicator information the CMO(W) confirmed that there was remaining headroom, he however cautioned that numbers in the other parts of the UK were increasing, and the situation would need close monitoring. The First Minister was clear that planning for the re-

opening schools would be the priority for available headroom which would place some constraints on the ability to relax further measures.

163. To build additional resilience into the testing system an investment of £32 million was made in August 2020. This enabled 24/7 operations at regional laboratories across Wales and the establishment of six hot labs within hospitals for rapid processing of Covid-19 tests. As a result of this investment we saw significant improvements in turnaround processing times via our NHS Wales laboratories, and sought to maximise our strengths and resilience through adopting a hybrid testing system which utilises both our domestic testing and UK lighthouse laboratory capacity.

164. The 21-day review on 8 September 2020 continued to present a concerning picture, with the CMO(W) noting concerns about increased cases in Wales and across the UK. In light of this it was agreed again that there was no clear headroom for significant easements to be made.

165. In phase 1, the CMO(W) wrote to almost 100,000 people who had been identified as most vulnerable to risk from Covid-19 and advised them to stay at home for 12 weeks as a protective measure. During phase 2, HSSG worked to put in place arrangements to support this cohort of clinically extremely vulnerable ("CEV") patients. In June 2020 in particular there was focussed engagement with stakeholders, including the Disability and Equality Forum. A specific communications plan was also developed where individuals could ask the CMO(W) questions which was well received.

166. Officials in HSSG continued to work closely with the NHS Wales Shared Services Partnership on PPE stock reports and, following a clear steer from the First Minister and Minister for Health and Social Services, looked to build resilience during the summer in preparation for the autumn/winter period and to protect PPE supplies for the health and care sectors in Wales as an immediate priority rather than wait for an agreed UK wide approach.

167. There was still a tremendous amount of activity across HSSG during phase 2. I was incredibly proud of what the HSSG had achieved, and the collaborative approach taken across government and externally, but I was also mindful of the difficulties the winter ahead posed for the health and care systems under normal circumstances and wanted to ensure the HSSG was in the best possible position to support the system. Following a discussion with the CMO(W) I asked that the HSSG undertake a review of its Covid-19 Planning and Response systems over the summer to ensure opportunities were

taken to learn from the first wave and introduce new actions and a revised approach where needed. Further detail on the outcome of this review, and subsequent reviews of the HSSG is detailed below.

Phase 3 – 1 October 2020 to 29 February 2021

168. This period, despite the initial peak we saw to April 2020, was in my recollection the most difficult and the most challenging. Whereas in phase 1 and 2 we had been able for proper reasons pause some of the NHS workload and refocus priorities, by this phase we were looking to restore services, building on core and essential services retained, as well as seeing the growing impact of Covid patients in our NHS bed capacity. We were heading for our first winter with an ongoing Covid response and whilst there was capacity available, there was concern about when and at what level of Covid patients in beds would the NHS be most challenged in terms of its resilience. We had to plan these normal winter pressures alongside the Covid context and knowing the impact on staff (and staff absence) as well as patients as community levels increased.

169. The Covid-19 Planning and Response Group continued to meet weekly throughout this period with the Planning and Response Cell providing support. The Senior Military Liaison remained in place and was supplemented by Military Liaison Officers placed in each of the seven Local Health Boards providing essential support, advice, and intelligence.

170. The HSSG group also commissioned operational data modelling to predict and track the overall Covid-19 demand on the system, in order to inform timely decision-making to prevent the system from being overwhelmed. This modelling data, in conjunction with the advice from TAC and the CMO(W), was critical in informing the advice to Cabinet on NHS capacity and resilience throughout this phase and to provide an assessment of current and prospective pressures.

171. HSSG commissioned TAC / TAG to provide the operational data modelling and data commissioning. This commenced in approximately May 2020 and continues today as an essential part of our intelligence. A significant amount of modelling was received from Swansea University or SPI-M-O academic groups (Scientific Pandemic Influenza Group on Modelling, Operational sub-group) such as the University of Warwick, the London School of Hygiene and Tropical Medicine and Imperial College London.

172. The conclusions of the operational data modelling were communicated to the HSSG via being shared with Executive Directors Team members, members of the HSSG Covid-19 Planning and Response Group, and NHS CEOs to help inform national and local planning assumptions. Both the CSA for Health and Chief Statistician have provided evidence to the Inquiry for Module 2B and would be better placed to discuss any limitations in data or modelling however the regular advice from TAC usually included the level of confidence for any conclusion. Information from TAC also included references and academic caveats and discussions of study limitations.

173. The Inquiry has asked for HSSG to set out what structures and processes were utilised or developed for the consideration and discussion of modelling. I understand that Glyn Jones (Chief Digital Officer) has provided a written statement to the Inquiry on behalf of Welsh Government Knowledge and Analytical Services. He is best placed to assist with questions in relation to consideration and discussion of modelling. However, I can state that the Covid-19 models were included in the Welsh Government's annual assurance exercise for analytical modelling from 2020 onwards. The aim of this exercise is to provide assurance that business critical models are operating within the assurance framework. Given the value and public interest in very timely data, quality assurance processes were necessarily modified during the pandemic in order to provide appropriate assurance in the time available. In the corporate statement I have provided for the Welsh Government (referenced M2B-WG-01) the approach to quality assurance is set out, alongside an example of how quality assurance standards and methods were applied in relation to the NHS management information on Covid-19 related activity, which was published weekly and then daily during the specified period.

174. The work supporting the Covid-19 project team with the 21-day reviews, particularly the updating of the Welsh Government Covid-19 guidance continued throughout phase 3, however the focus was very much the preparation and action that needed to be taken to mitigate risks and ensure the on-going delivery of health and care services through the winter period.

175. The next 21-day review took place on 1 October 2020. Once more we were seeing significant increases in cases. The data from Test Trace Protect was showing 4-5 contacts per case, which was a sign that people were socially mixing more. There was concern at an increase in cases among people aged over 60 leading to increased pressures on the NHS intensive care wards. Considering this position, the decision was taken not to lift restrictions at a national level (during this period local lockdowns were also in place in some parts of Wales). As had become standard the key indicators

paper was included in the briefing pack to Ministers to show the position of the NHS in Wales.

176. On Thursday 15 October 2020 at a Cabinet meeting the First Minister informed Ministers that he had called the meeting to seek the agreement of Cabinet to apply a 'circuit breaker' (fire-break lockdown) to the whole of Wales to reduce the significant increase in the transmission of the virus. Advice from the CMO(W), the CSA for health and the TAC all reflected that of the UK Government's Chief Scientific Adviser, Sir Patrick Vallance, to COBR, that the UK Government's proposals for a three-tier system would not stop the rapid spread of the virus and a 'circuit breaker' system was the preferred option. Cabinet agreed in principle to introducing a fire-break lockdown. It was also agreed that Ministers would meet again the following Monday (19 October) to consider the recommendations in detail and take a substantive decision. I exhibit as **AGM2BHSSG01/36-INQ000048796** (dated 15 October 2020) the relevant Cabinet minutes. On Sunday 18 October 2020 the fire-break was discussed further by Cabinet. I exhibit as **AGM2BHSSG01/37-INQ000048801** (dated 18 October 2020) the relevant Cabinet minutes. The following day (19 October 2020) Cabinet met to take a decision on whether to apply the proposed fire-break. It was agreed that there would be a two-week fire-break, starting at 6pm on Friday 23rd October and ending on Monday 9th November. I exhibit as **AGM2BHSSG01/38-INQ000048802** (dated 19 October 2020) the relevant Cabinet minutes.

177. On 29 October 2020 I attended Cabinet once more to discuss the post fire-break situation and recovery arrangements. At this time, it was too early to see from the key indicator data what impact the fire-break had had on transmission rates and NHS capacity. The number of cases in hospitals were stable, albeit increasing, whereas intensive care beds were being dominated by non-Covid-19 patients. It was a particularly tense time as I, and others working closely with the sector, were very aware that the situation could change quickly. Meeting again soon after on 1 November 2020, Cabinet discussed the measures that were needed when the fire-break ended on 9 November 2020, agreeing that there needed to be a two-week post fire-break review to assess the impact of the fire-break and the NHS situation.

178. During this period the HSSG Executive Director Team Contingency Group was established. I exhibit the group's terms of reference as **AGM2BHSSG01/39-INQ000231290** (dated 26 October 2020). The Executive Directors Team Contingency Group met weekly, on the Wednesday of each week, with the ability to call extra meetings as and when required. The group was intended to provide a more focused

oversight of the risks and issues arising from the Covid-19 pandemic but also recognising and addressing concurrent risks arising EU Exit and the winter pressures on the health and social care systems. As part of this reset TAC started to report into the Executive Directors Team Contingencies Group to ensure the Group had full oversight and accountability across all aspects of the HSSG Covid response.

179. On 11 November, the welcome news that a Covid-19 vaccination could be available by the end of the year gave everyone a significant lift. As noted above, officials in HSSG had already commenced work in phase 2 on the operational work for the vaccine programme, but these arrangements were stepped up. As the Welsh Government's vaccination programme will be the subject of a later Inquiry module additional detail has not been set out in this statement, but the work of the HSSG on bringing together the complexities of procurement, supply, storage, distribution and administration of the vaccine is something I was extremely proud of and, as the summary of the subsequent phases sets out below, had a significant impact on NHS capacity enabling us to emerge from pandemic. We later saw Wales deliver vaccination levels amongst the best in the world, benefitting from the delivery model we planned for at this stage.

180. At the Cabinet meeting on 16 November 2020 the CMO(W) outlined that the fire-break had thankfully interrupted transmission and the R rate was now at 0.8. Hospitals were reporting trends of stabilisation and reduction, but we remained concerned about potential rises in cases in December which, due to the usual winter pressures, would place the NHS once more under considerable strain. There was a discussion around what potential regulatory interventions over the winter may be needed, particularly in light of the mounting, understandable, public interest in what the restrictions would be over the Christmas period. It was recognised how difficult the last year had been for the people of Wales, but Ministers recognised that decisions around the control measures needed over Christmas would need to be taken cautiously and with all available scientific, technical and operation data available. Cabinet requested that they receive information on the short- and medium-term position of the NHS in being able to deal with further surges in transmission rates. Current available modelling took figures to 15 December 2020 but those figures did not take account of the fire-break.

181. Prior to the Cabinet meeting on 26 November 2020, myself, Frank Atherton and Rob Orford, were asked to provide a presentation to Ministers outlining our recommendations for the approach to winter planning. This was an extremely worrying time in the pandemic, and the context to the decisions Ministers would need to take in

terms of both the epidemiology of the virus and NHS capacity was very serious. In my presentation to Ministers I spoke openly and honestly about the extreme pressures on the NHS and care system and the concerns of system collapse based on the modelling that Frank Atherton and Rob Orford spoke to.

182.The Inquiry has asked HSSG to confirm who asked myself, Frank Atherton and Rob Orford to present to Ministers and when. Attendance by officials at Cabinet would be determined by the issues on the agenda and any requests from Ministers. For example, myself as Director General HSS, or the CMO or CSA for Health would not routinely attend Cabinet other than by invitation. Given the approach to the 21-day review process and consideration of the three pillars for leading Wales out of restrictions, as outlined in paragraph six of this statement, we each addressed one of those pillars. I considered pillar 1 (measures and evidence in terms of NHS capacity), the CSA for Health pillar 2 (scientific principles) and the CMO pillar 3 (the public health purpose). In terms of whether we 'presented' at Cabinet (as opposed to submitting papers) that was determined by the First Minister who chaired the session.

183.The Inquiry has also asked for copies of presentations delivered by representatives of the HSSG at the Cabinet meeting (on 26 November 2020), and for documents provided to Ministers in advance of the meeting. The presentations were delivered to Ministers the evening of 25 November. I confirm that any information provided during Cabinet by HSSG representatives is included in the minutes. In terms of papers provided I exhibit the following Cabinet Papers:

i. **AGM2BHSSG01/40-INQ000129864** (dated 25 November 2020);

ii. **AGM2BHSSG01/41-INQ000048898** (dated 25 November 2020);

iii. **AGM2BHSSG01/42-INQ000048897** (dated 25 November 2020);

iv. **AGM2BHSSG01/43-INQ000048896** (dated 25 November 2020); and

v. **AGM2BHSSG01/44-INQ000048899** (dated 25 November 2020).

184.I have outlined above in this statement the intimate nature of the NHS in Wales and the close working relationship I and others in the HSSG had with Local Health Boards and health service providers. We were from an NHS perspective concerned about resilience and outcomes and the information provided at this Cabinet meeting has been shared and discussed with NHS leaders to ensure the NHS view was accurately reflected. I was grateful that Ministers and Cabinet fostered an environment in which I

could update how it was and how it felt and give a consistent position internally and externally - this trust to be able to speak honestly was really important to me in discharging my role and gave confidence to the wider NHS. Cabinet listened and agreed action to protect the NHS and save lives was needed, agreeing the following day to introduce further restrictions in the run up to Christmas, to release some headroom to enable families to meet over the Christmas period. In setting out the NHS view this did not disregard the social care system as the integrated system in Wales meant that in discussing NHS capacity, we were considerate of the impact on social care and views of providers which was embedded in our Planning and Response structure.

185.On 9 December 2020, Cabinet met to take decisions around the post-Christmas period. At that time case rates were continuing to rise, and the CMO(W) outlined that notwithstanding the possibility that recently introduced restrictions might bring about some stability, there remained concerns that the easements over Christmas would bring about an inevitable rise in transmission rates during late December and early January. HSSG were already in discussion with the health service on planning for increases in Covid-19 related admissions. Officials now sought agreement in principle that stricter restrictions be introduced on 28 December 2020 if transmission rates did not show a significant improvement before then.

186.Given concerns about the potential risk of harm to patients who required essential services, HSSG worked with the sector to agree a framework of actions to mitigate the risk of harm – referred to as the Local Options Framework, which was issued on the 10 December 2020. I exhibit:

i. An email chain (the last email of which is dated 19 January 2021) as **AGM2BHSSG01/45-INQ000083245** which shows the issuing of the following documents on 10 December 2020;

ii. Letter entitled "Potential options for service suspensions and redeployment in Covid peak" authored by me dated 10 December 2020 is exhibited as **AGM2BHSSG01/46-INQ000083246**;

iii. The Local Options Framework for winter 2020 – 2021, dated 10 December 2020 is exhibited as **AGM2BHSSG01/47-INQ000083247**;

iv. Letter entitled "Urgent care system pressures" authored by me dated 10 December 2020 is exhibited as **AGM2BHSSG01/48-INQ000083248**); and

v. A document entitled “Urgent care system pressures - Copy of UEC HB matrix” dated 10 December 2020 is exhibited as **AGM2BHSSG01/49-INQ000083249**.

187. Within social care there were also concerns of increased loneliness and isolation following Christmas and the need for lone carers to continue to bubble with their family.

188. Despite our forward planning and consideration of the modelling, the emergence of a new variant of coronavirus (B117) in mid-December 2020 required a rapid reassessment of our planning and assumptions for this period. Cabinet met on 19 December 2020 and following Chris Jones, the Deputy CMO(W)’s summary of the public health situation, I outlined that there were now more than 2,200 Covid-19 patients in beds, of which more than 1,000 were confirmed. This was running ahead of the current reasonable worst-case scenario. The NHS was concerned about resilience with pressure expected to increase into the new year. The Welsh Ambulance Service was already experiencing issues. Critical care capacity was currently at 200, of which 100 were Covid-19 patients, with a current trend of 25% weekly growth. The planned restrictions for 28 December were brought forward immediately to take effect later that night.

189. The impact of the new variant had led to the four UK CMOs on 4 January 2021, following advice from the Joint Biosecurity Centre (“JBC”), to raise the risk level to the highest possible - Joint Biosecurity Centre Level 5.

190. Cabinet was reconvened on 6 January 2021 for the next 21-day review of the Regulations. The CMO(W) confirmed that cases remained 'very high' in most parts of Wales. At this time the NHS in Wales was still in a very challenging position as the number of people admitted to hospital with Covid-19 symptoms continued to rise. The firm recommendation to Ministers was that the current restrictions would need to be maintained.

191. Cabinet met again on 11 January 2021 by which time we had begun to see some very slight improvement. The CMO(W) reported a slight overall reduction in transmission rates across Wales, but parts of Wales such as Wrexham still had worrying figures. The hospitals remained under considerable pressure, but admissions were not increasing exponentially. Options for easements at the next review date were to be explored cautiously in the hope that the early actions taken in December would continue to show some stabilisation as we moved to the end of the month and into the next review period.

192. On 25 January 2021 the 21-day review update showed that since early January there had been a fall in community transmission rates. I was asked to summarise to Cabinet the position with hospital capacity. There were 2,700 confirmed, suspected or recovering Covid-19 patients occupying beds. Of these there were 1,400 confirmed cases. These were within the planning scenario, which suggested that there could have been as many as 3,500 suspected cases occupying beds at this stage if the Government had not intervened before Christmas. We did come close to this figure with a pandemic high of around 3100 patients in beds, either confirmed, suspected or recovering – this became a benchmark for subsequent phases as it was the peak to track against both for critical care and general beds. There was also concern over critical care capacity, as at one point there had been a 25% weekly growth in numbers, but this was now dropping by around 8% per week. Nevertheless, the intensive care units were still very busy with both Covid-19 and other patients.

193. If Ministers had not acted to put in place restrictions, this would have continued to deteriorate and given our underlying objective to ensure the NHS was not overwhelmed, and the impact of that, would have in my professional view come close I think to a tipping point for the NHS in its ability to cope. While, these exceptional circumstances were managed within the NHS and hospitals were being flexible to accommodate the extraordinary number of additional patients, this would however have a long-term impact on the ability of the NHS to deliver other health services.

194. Cabinet agreed that, as indicators remained high across Wales and the capacity of the NHS was a matter of concern, the country should remain at Alert Level 4 until the next review. When we arrived at the next 21-day review on 18 February 2021 the position was much more positive. The situation was improving across Wales with the seven-day average around 88 in every 100,000 of the population. Pressure on the NHS was easing and only Powys Teaching Health Board was reporting an increase in cases. Over 780,000 people in Wales had now had their first dose of a vaccine.

195. We did remain cautious, however, as the new variants had created uncertainty about how swiftly cases may rise if restrictions were lifted too quickly, and there was also a need to understand whether the vaccines would have an impact on transmission rates and how effective they would be in protecting the whole population. For these reasons Cabinet agreed to maintain the 'stay at home' lockdown measures under Alert Level 4, however, should conditions continue to improve by the next review, it was considered possible to begin moving out of the 'stay at home' restrictions.

196. This period was an extraordinarily difficult time with real commitment across HSSG and by staff working in the NHS and care to focus on patients and those needing care. My firm view is that without the Welsh Government actions leading up to the Christmas period I believe there would have been more cases, more admissions and sadly more deaths. There were genuine concerns that the NHS could have been overwhelmed, although this still represent a very challenging and difficult period for the resilience and response of the NHS. When beds are occupied in high volume by covid patients, the NHS is unable to discharge fully its broader responsibilities and activities.

Phase 4 – 1 March 2021 to 30 September 2021

197. It was important during this phase that we looked ahead and did so with some optimism. The Covid-19 vaccination programme (not detailed in this statement as it will be the subject of a later module) had made excellent progress and we were optimistic that there would be a return to "normal" soon. With this in mind the HSSG developed and published an overarching Recovery Plan, Health and Social Care in Wales – Covid-19: Looking Forward, **AGM2BHSSG01/50-INQ000083250**, dated 22 March 2021, refers, which set out the expectations for the months and years ahead and tried to give some clear focus on expanding a more normal range and experience of NHS services and activity.

198. As we moved into the Spring/summer of 2021 the HSSG priorities continued to be to support the central Covid-19 protect team in the review of the Restriction Regulations, to protect the wellbeing of the workforce and to prevent health and social services from being overwhelmed as it continued to balance Covid-19 response with other health and care activities. At this time, we were emerging from a second wave and the public expectations of the NHS response began to shift as the coronavirus restrictions across society began to relax.

199. The HSSG Covid-19 Planning and Response Group continued to meet regularly, although the frequency of the meetings reduced to fortnightly over the spring and into summer but then resumed weekly meetings as the end of summer and consideration of winter pressures commenced. In July 2021 the formal involvement of the Senior Military Liaison came to an end however informal contact was maintained with a view to considering re-instatement of support should that become necessary.

200. The pace of the activity of the HSSG during this period was focused on the delivery of the vaccination programme for Wales and the Test Trace Protect systems. Officials in

HSSG and the external stakeholders all felt the tremendous pressure of the public's hopes for the vaccine programme to deliver a way out of the pandemic and see a return to more normal experiences of our society. Officials worked closely with TAC and CMO(W) office to understand the impact of the vaccine programme on transmissibility and the interplay with variants, into order to inform the policy approach to isolation guidance and Test Trace Protect.

201.The Nosocomial Transmission Group facilitated the development and issue of extensive guidance on subject such as infection prevention and control guidelines, PPE, Covid-19 testing, cleaning standards, ventilation, and environmental controls. The HSSG also worked closely with Local Health Boards and Public Health Wales to ensure hospital outbreaks are brought swiftly under control and to prevent further outbreaks.

202.At the 21-day review on 8 March 2021 the public health situation outlined by the CMO(W) showed continued improvement. The seven-day average was around 47 in every 100,000 and the number of people with confirmed Covid-19 in hospital and ICU was continuing to decrease. Officials recommended a gradual reduction from Alert Level 4 which was agreed by ministers.

203.By the next 21-day review point on 29 March 2021, there was a stable situation broadly across Wales with the seven-day average at around 39 in every 100,000 of the population and the number of people with Covid-19 in hospital decreasing. The vaccination programme was continuing to progress well. Officials in the HSSG Public Health Division advised a cautious approach should still be taken as the easements agreed at the last review had been gradual and staggered, so there was still not a sufficient lapse since the last easement to assess the impact it had. It was agreed by Cabinet that the First Minister should signal the further, gradual lifting of restrictions which could take place over the next few weeks providing the health conditions remained favourable.

204.The public health situation remained stable at the next 21-day review on 19 April 2021. The seven-day average had reduced to 16 or 17 per 100,000 of the population. Vaccine uptake continued to be positive but the extent to which vaccination had broken the link between community transmission and direct Covid-19 harms was not yet clear. Concerns about variants remained high after the 'Kent variant', particularly in light of plans to recommence international travel in May. Again, a cautious approach was recommended, with a package of easements moving Wales fully to Alert Level 3 and

then slowly transitioning into Alert Level 2, provided the conditions remained favourable.

205. Cabinet met again on 10 and 12 May 2021, at which time the overall number of confirmed cases was gradually decreasing and the situation was relatively benign. Testing data demonstrated that test positivity for Covid-19 continued to fall consistently. The pattern was similar across the UK, but with Wales still having the lowest number of cases. Over 75% of the adult population had received their first vaccination dose, with one in four in receipt of their second. Signalling for a move to Alert Level 1 on 7 June 2021, if the health condition remained favourable was agreed.

206. Cabinet met on 17 May 2021 and discussed concerns around another variant, B.1.617.2 (later identified as the 'Delta variant') which was circulating. There was very little data available on the new variant and it was not clear at this point if it could result in more severe symptoms, resulting in hospitalisation and pressure on the NHS or whether it was sensitive to vaccines. The signalling for June might have needed to be reassessed but it was too early to take decisions.

207. Cabinet met again at the end of May, ahead of the June 21-day review day to assess the options available. The seven-day average was less than ten in every 100,000 of population and the positivity rate was just below one percent. There was however still concern about the Delta variant (B.1.617.2), with 59 confirmed cases in Wales. Test Trace Protect was however containing outbreaks in Wales. I reported that there were currently 179 people occupying hospital beds with suspected Covid-19 symptoms, with only eight confirmed cases. Three of these were in critical care beds. Overall occupancy was 95% lower than the peak, with a 99% reduction in those in critical care beds. The NHS was focusing on the recovery of normal services and dealing with the usual emerging pressures rather than those Covid-19 related. When Cabinet reconvened on 3 June 2021 as staged step down to Alert Level 1 was agreed, with the most risky easement being delayed to the 21 June 2021.

208. An interim review of the Restrictions took place on 16 June 2021. Case rates were increasing in Wales but this was primarily among the younger generations and therefore was not impacting NHS services as seriously although I should emphasise that the NHS was exceptionally busy and under pressure. It was still not clear if the vaccine programme was weakening the link between community transmission and seriousness illness, but the advice was to increase the scope of the vaccination

programme as much as possible to enable a higher proportion of adults to take up the second dose of the vaccine.

209. On 12 July 2021, while the community transmission of Covid-19 was high with case numbers increasing, mostly amongst younger less vaccinated people, the pressure on the NHS in Wales remained stable and it was experiencing the lowest levels of Covid-19 since reporting had begun, although we were aware that if cases continued to rise rapidly at any point so could hospital admissions. The CMO(W)'s advice indicated that the current epidemiological picture changed the balance between direct and indirect harms and made it increasingly difficult to justify the stringent use of public health powers to continue restricting economic, social and cultural activities. It was agreed to signal a move to Alert Level 0 in Wales.

210. At the next review on 29 July and 2 August 2021, the picture had changed again. While case rates were high Covid-19 pressure on the NHS remained well below levels seen in previous waves. The number of new daily hospital admissions with suspected or confirmed Covid-19 remained close to the lowest levels seen, however there had been a slight increase in the number of beds occupied with Covid-19 related patients in recent weeks from 10 daily to around 20. This was still at the lower end of numbers during the pandemic response and in line with more optimistic scenarios. In terms of the vaccination programme, as of 22 July, 90.1% of adults in Wales had received their first dose, and 78.8% had received their second dose, which equated to more than 2 million people.

211. Self-isolation requirements were causing system pressure and removing self-isolation would ease the burden on these sectors. Having fully considered the balance of harms, Cabinet agreed to remove the requirement to self-isolate for people who were identified as close contacts, if they had been fully vaccinated for at least 14 days.

212. HSSG officials were engaged with updating the Welsh Government Covid-19 Guidance and with working with UK Department of Health and Social Care in updates to the NHS Covid-19 App to enable Test Trace Protect staff to be fully integrated with the vaccine checking system in order to verify the vaccination status of some contacts, however, tracing efforts would be focused on younger people who were less likely to be fully vaccinated, mitigating the risk.

213. The situation remained largely the same at the next review on 23 August 2021. I was able to report to Cabinet that, despite ongoing pressures, all Local Health Boards

remained within the current operational modelling for the pandemic. The vaccination programme was continuing at pace, with HSSG officials working hard to make a significant push to reach out to those who were reluctant to accept the vaccine. Given the reports on the public health situation, Cabinet agreed that Wales should remain at Alert Level 0 for the current review period.

214. At the next 21-day review on 16 September 2021 I reported that hospital and ICU admissions had continued to rise, with 563 beds being occupied by Covid-19 related patients. Local Health Boards were now at the high end of the operational modelling for the pandemic, and it was hoped that this would stabilise shortly. Those receiving critical care had reduced over the past week.

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215. While Wales remained at Alert Level 0 there were still pressures across the NHS and care sector. Overall, the NHS was the busiest it had been for a number of years; in addition to the pressures of Covid-19, there were record numbers of emergency admissions along with pent up community demand and recovery efforts. Local Health Boards were taking local decisions to deal with the pressures, which included the postponement of routine operations and the suspension of hospital visits.

216. At the 21-day review on 4 October 2021 the Deputy CMO(W) advised that of the four nations, Wales now had the highest infection rate. The highest rate of infection was amongst the under 25s, where cases were around 1,000 in every 100,000, whereas infection rates in the over 60s were stable, with 205 cases in every 100,000 being reported. I informed Ministers that that there had been improvements within the Health Service and the number of Covid-19 related patients occupying hospital beds had reduced to 600. There had also been corresponding reductions in confirmed cases and those in critical care units. All Local Health Boards were below the current operational modelling for the pandemic.

217. At the next review point on 25 October 2021, Wales continued to have the highest infection rates in the UK. I informed Ministers that Local Health Boards were still under a great deal of pressure, of which responding to the pandemic was one contributing factor. There were currently 726 Covid-19 patients occupying hospital beds, 520 of which were confirmed cases, and 53 people were in critical care units. The virus continued to have an impact on how NHS services were delivered as patients had to be managed through the system, while hospitals responded to staff shortages due to

sickness and self-isolation requirements. Given the ongoing public health situation, Cabinet agreed that the restrictions should be maintained for the current review period. However, there was a need to consider how these mitigations could be strengthened. A revised Local Options Framework was issued on 1 October 2021. I exhibit:

i. An email chain (the last email of which is dated 1 October 2021) as **AGM2BHSSG01/51-INQ000083251** which shows the issuing of the following documents on 1 October 2021;

ii. The Revised Local Options Framework, dated 23 September 2021 is exhibited as **AGM2BHSSG01/52-INQ000083252**; and

iii. Letter entitled "Revised Local Options Framework", dated 1 October 2021, is exhibited as **AGM2BHSSG01/53-INQ000083253**.

218. On 15 November 2021 review of the Regulations my attendance at Cabinet was in a different capacity, as I had taken up the role of Permanent Secretary and Judith Paget was in attendance as the Director General HSS. By this time Covid-19 pressures on the NHS had stabilised. As cases of Covid-19 had fallen across Wales, and the specific pressures on the NHS were at lower rates than previous waves, Cabinet agreed the current Alert Level 0 requirements should be maintained. The position was largely unchanged by the end of November when the next review point took place, but there was a noted increase in transmission in mainland Europe, so while Wales remained stable the steer from Cabinet was that officials should prepare for an urgent response should case rates increase in Wales.

219. As it transpired when Cabinet met a few days later on 29 November 2021, the CMO(W) provided advice on Omicron, a new variant of concern which was first reported by South Africa to the WHO the previous week but was now rapidly becoming the most dominant variant in that country. Since then, the variant had been identified in mainland Europe, Scotland, and England, and it was only a matter of time before cases would appear in Wales.

220. Further Cabinet meetings took place during the first week of December 2021 to address the threat of Omicron as well as undertake the statutory 21-day review which was due on 9 December 2021. Andrew Sallows, as Delivery Programme Director for the NHS, indicated that those in hospital with Covid-19 continued to fall. The situation was also improving with those in critical care, with now only 47 beds occupied by patients with coronavirus. However, these occupancy rates were still above the

historic maximum and a cause for concern in light of what we understood of Omicron at that time and its potential impact.

221. The public health response would be to try to control entry of the new variant into the country and then slow its introduction into the population by using Test Trace Protect and requiring those infected and close contacts to self-isolate. Vaccinated individuals would be encouraged to test before meeting socially and advice was to wear facemasks were possible. The HSSG updated Covid-19 guidance and messaging to ensure strong lines on the need to participate in Test Trace Protect and to self-isolate if a close contact. The emergence of the Omicron variant placed significant pressure on Test Trace Protect services, with the highest level of demand for testing that we had ever experienced during December and January. PCR testing levels reached over 200,000 a week in late December/early January, surpassing the levels seen in September 2021. There was also a significant demand for Lateral Flow Devices ("LFDs") that required us to work with UK Health Security Agency ("UKHSA") to increase distribution capacity and procure additional tests. This involved distribution levels reaching over five million a week compared to around one million distributed during November.

222. The Senior Military Liaison support to the Group was formally stood down in July 2021, however informal liaison and contact remained. Discussions were therefore reactivated in December in light of the emerging new variant to horizon scan potential risks and to test contingency plans. In mid-December the expectation was that an Omicron wave would last until March 2022. Additional restrictions were introduced on Boxing Day to mitigate the risks to the NHS. Notably a MACA request was submitted by the Welsh Ambulance Service Trust and approved to provide significant military personnel capacity until the end of March 2022.

223. Cabinet reconvened on 10 January 2022 for an update across portfolios on the Covid-19 situation. In respect of the HSSG, Judith Paget (Director General HSS) outlined that there were 500 more people in hospital beds when compared to the same time the previous year. Of the 8546 patients, 1,030 were Covid-19 related, with 786 confirmed cases. This was an increase of 40% over the previous week. Critical care was in surge capacity, of the 170 patients occupying ICU beds only 42 were coronavirus related. There was still an issue with people acquiring Covid-19 in hospital and there had been an increase in people attending health care settings with other illnesses, who were subsequently being identified as positive for Covid-19.

224. More critical for the NHS were staff absences due to sickness and self-isolation requirements, which were between 8-15%, with nursing and midwifery being the most affected. Absence numbers were expected to increase. Therefore, some appointments and treatments had been postponed and staff were being transferred to work in urgent and emergency services.

225. The formal 21-day review took place on 13 January 2022 and noted thankfully that hospital admissions due to Covid-19 were reducing, with 58% of infections now being identified as a coincidental illness, and the number of people in ICU also falling. Furthermore, the rate of harm caused by Omicron appeared to be less serious for those that had been vaccinated. Advice from TAC was that the expectation was that the peak of the Omicron wave, in terms of cases, had either already been, or would very soon be, reached. Therefore, a staggered approach to lifting the protections was proposed, with the caveat that the public health situation must be favourable at the time.

226. The next formal review, on 10 February 2022 continued to show a positive outlook. Judith Paget updated on the position in the NHS, outlining that Covid-19 pressures in the NHS was lower than previous waves, with 1,140 patients currently occupying hospital beds, of which there were 531 confirmed cases. It is worth noting that despite the improvement, these still represented significant numbers of beds out of normal use due to being accommodated by Covid-19 patients. The number of incidental cases were increasing, with data suggesting that only 30% of patients required treatment for the virus. The number of Covid-19 related patients in intensive care had reduced to 13, but overall units were very busy with 170 beds occupied. Furthermore, in overall bed terms there were 750 more people in hospital than in the same period the previous year showing higher levels of non-Covid-19 activity. Staff absences across NHS Wales were around 7% and there were similar pressures in the care sector. As we emerged from the pandemic it was important to manage public expectation of the NHS as services returned to some form of normality and we reset the definition of "normal" in a Covid-19 context.

227. At the next review which took place on 28 February 2022, Cabinet again noted the improving situation and justification for the continued easing of restrictions, and the option to allow the Regulations to expire was noted. As the situation improved Cabinet outlined plans for a 'Transition Plan' to move from Covid-19 as an emergency response to it being dealt with in line with other infectious diseases.

228. A further variant of concern raised alarms at the time of the next review on 21 March 2022. This was a sub-variant of Omicron, BA.2. Case rates were rising again along with ICU admissions and there was a need to pause the review and consider the emerging evidence. Cabinet reconvened a few days later and took the view that while they would not add further restrictions, the Regulations were still required to remain in place.

229. On 12 April 2022, Cabinet met once more at which point Covid-19 was still prevalent across Wales and the wider UK and continued to cause pressure on the NHS; however admissions had now plateaued to around 40 per day. Those in intensive care with the virus had remained lower than in previous waves. The latest modelling from Swansea University indicated that medium term projections from 1 April suggested a less challenging scenario, with up to 1,700 beds occupied by Covid-19 patients, compared with around 2,500 projected the previous week. While the legal requirement for face masks in health and social care settings was retained, the remaining restrictions, including requirements on business to take reasonable measures, were lifted.

230. On 23 May 2022 Cabinet met for what would be the final 21-day review. Infection rates driven by Omicron had started to wane and the situation in the NHS was stabilising. The decision was taken at this review that the legal basis for the Regulations, as a response to a public health threat, was no longer justified. It was however agreed that the Welsh Covid-19 Guidance should continue to advise the use of face-masks in health and care settings. The Regulations therefore expired on 30 May 2022.

Consideration of the impact of NPIs on at risk and vulnerable groups and those with protected characteristics

231. Prior to and during the pandemic period we were conscious of the significant impact the health care system could have upon groups such as disabled poeple, clinically vulnerable, ethnic minority people and those with poor socio-economic backgrounds or with existing health inequalities.

232. A key principle adopted by the Welsh Government during the pandemic centred on whether the measure being introduced or removed would have a 'high positive equality impact'. In addition, the Welsh Government was mindful of the need to mitigate against the four harms (later expanded to include a fifth harm) arising from the pandemic.

233. Throughout this period decision-making by the Welsh Ministers continued to be assessed against their statutory duties. The Welsh Ministers were required to

undertake equality impact assessment as part of their duties under the Equality Act 2010.

234. Impact Assessments are an important part of policy making, and the Welsh Government has statutory obligations (or has made commitments for the consideration of) a number of areas of impact when developing policy. These include equality, the Welsh Language, biodiversity, children's rights, rural-proofing, data protection, justice, health, privacy and a range of environmental impacts. For decisions of a strategic nature there is also a duty to consider their socio-economic impact.

235. Within the Welsh Government the usual tool used to assess impact is the Integrated Impact Assessment ("IIA") which brings together all impact assessments into one comprehensive document. The document also requires consideration of how the policy proposal fits with the priorities and vision of the programme for government, and how it contributes to the social, cultural, economic and environmental well-being of Wales (aligning with the Well-being of Future Generations (Wales) Act 2015 and the sustainable development principle).

236. Ministers would also be provided with information about the economic and societal implications of the options under consideration. Ministerial advice recommending decisions for the health care system would include impact assessments of the options, including the impacts on particular socio-economic groups and groups with protected characteristics. Summaries of impact assessments were published were possible. The need to make decisions at pace for the protection of public health meant that it was not always possible to undertake full intergrated impact assessments in line with best practice for policy decisions of the measures being considered.

237. In respect of decisions taken by the Welsh Government during the pandemic, due to the urgency of the situation and exponential increases in Covid-19 transmission decisions at the start of the Covid-19 pandemic were often made without a formal assessment of the impact on vulnerable people. However, issues of equality and vulnerability were part of the consideration of some of our early actions and part of the balancing of Covid-19 related harms as outlined above and set out in 'Leading Wales out of the coronavirus pandemic' as exhibited earlier as **AGM2BHSSG01/1-INQ000083221**.

238. In respect of the Covid-19 Restrictions in Wales, Public Health Wales provided a wealth of data via their Public Engagement Survey which they started conducting

around April 2020. Each week, Public Health Wales would conduct interviews with people across Wales, to understand how Covid-19 and the measures being used to prevent its spread were affecting the physical, mental and social wellbeing of people in Wales. The outcome of this survey would be provided to the Knowledge and Analytical Services team and provided an important insight into the impact of the Welsh Government's response to Covid-19.

239. In August 2020, the Senedd's Equality, Local Government and Communities Committee recommended that the Welsh Government should ensure that each major policy or legislative decision during the pandemic should be accompanied by an effective equality impact assessment (EIA), and an analysis of the impact on human rights. The Welsh Government accepted the recommendation, and since that time has published dozens of impact assessments related to the Covid-19 pandemic on its website. These impact assessments include the findings from Public Health Wales' Public Engagement Survey. A list of all published Equality Impact Assessments is provided in exhibit **AGM2BHSSG01/54-INQ000227405** (date of document 23 June 2023). Officials from the HSSG involved in the aspects of the restrictions and NPIs would have contributed to the Equality Impact Assessment process.

240. In relation to the identification and consideration of 'at risk' groups and other clinically vulnerable persons this was initially led by the CMO(W)'s office overseeing work on the clinical criteria to apply to identify this group and I understand has outlined this in his statement to the Inquiry. In recognition that this would require a cross government response, particularly in respect of ensuring appropriate support was in place for this cohort. Amelia John, Deputy Director was asked to act as the Senior Responsible Officer to coordinate the Welsh Government response to supporting vulnerable people. Amelia was not a member of the HSSG but was able to request information and support as needed from the HSSG.

241. In terms of actions by the HSSG, on the 2 April 2020 a video consultation service was rolled out to all GP practices in Wales and on the 5 April 2020, arrangements were entered into with the National Pharmacy Association to provide additional capacity to the existing medicines delivery service provided by community pharmacies in Wales which would assist those isolating or shielding at home.

242. I wrote to the NHS bodies on the 5 May 2020 setting out a number of actions Local Health Boards needed to take to ensure cancer services provision. This included action to put in place support systems able to deal with concerns from cancer patients

regarding social isolation, shielding and the likely benefits and harms of ongoing cancer care. A copy of this letter is exhibited as **AGM2BHSSG01/55-INQ000227155** (dated 5 May 2020, please note there is a typo in relation to the date on the document itself).

243. Analysis of the characteristics of those clinical extremely vulnerable was also undertaken by Knowledge and Analytical Services using the National Survey for Wales data. In August 2020 Knowledge and Analytical Services undertook an analysis of those on the Shielded Patient List access to green spaces. A copy of this analysis is exhibited in **AGM2BHSSG01/56-INQ000227225**, dated 29 July 2020. In 2021 analysis was undertaken exploring whether the people on the Shielded Patient List also had other non-clinical vulnerabilities. A copy of this analysis is exhibited in **AGM2BHSSG01/57-INQ000227381**, dated 2021.

Divergence

244. The Inquiry has asked the extent to which the Welsh Government made decisions about NPIs which diverged from decisions made by the UK Government, and to set out the factors which the HSSG consider assist in understanding why there was a difference in approach. The HSSG's focus was the health and social care system and the extent to which there was sufficient capacity to deal with a rise in Covid-19 cases. However, I understand that Reg Kilpatrick and Tom Smithson are to provide / have provided written evidence to the Inquiry where they outline the instances where divergence occurred, and the reasons why. Examples such as the firebreak lockdown, international travel regulations, and attempts to coordinate approaches for Christmas 2020 are discussed.

245. In terms of the factors which informed different decision-making as I have outlined throughout this statement the HSSG covered a wide remit and factors including NHS capacity, Test Trace Protect, social care capacity, infection prevention control measures in different settings, PPE and vaccination were all matters which impacted decision making. As outlined above I attended the 21-day reviews to provide Cabinet with an outline of NHS capacity which was a clear factor in decision-making, however other members of the HSSG such as the CMO(W) and CSA for Health also attended or prepared papers which outlined a range of factors which Ministers considered in the decision-making process.

246. The Inquiry also asks whether there were any significant decisions which the Welsh Government made which the HSSG advised against or disagreed with. In addition, whether there were there instances whereby information received by the Welsh Government was not promptly notified to the HSSG, and if that caused problems. In response I would state that decisions made by the Welsh Ministers were made based on advice and information coming from officials in the Welsh Government, including the HSSG. I am not aware of decisions being made which the HSSG advised against or disagreed with. As I have outlined previously in this statement officials acted without fear or favour and within discussions with Ministers and within the HSSG structures open discussion was actively promoted. In my experience Ministers did not discourage challenge from officials or within Cabinet but challenge and discussion does not prevent consensus from forming. Information from within other directorates in the Welsh Government was promptly notified to the HSSG. One issue we did have was getting timely information from the UK Government, which could at times delay the HSSG in formulating its advice or causing confusion. An example of this, which I understand will be considered in more detail in later modules, is in relation to guidance on discharge from hospital. UK guidance was published without advance notice to the HSSG, resulting in questions from the sector coming in.

The Border

247. In terms of the advice given by the HSSG in respect of NPIs, as noted this was in relation to NHS capacity in the Welsh NHS. The land border with England did not impact upon that advise per se, other than the fact that we did have an established system which was in place prior to the pandemic where NHS Wales would commission services for Welsh patients to be received across the border, for example in the case of High Consequence Infectious Disease ("HCID") beds of which there were none in Wales and were commissioned from England. Additionally, individual Local Health Boards would also directly enter into commissioned services arrangements with the NHS bodies in England, particularly those Local Health Boards with populations living on or close to the border.

Herd Immunity

248. The Inquiry asks the extent to which HSSG considered herd immunity as a potential means of responding to the Pandemic. In response I would state that I understand herd immunity to be an epidemiological phrase and that within the HSSG there are few individuals who would be able to advise on this, for example the CMOW) or CSA for

Health. My understanding and recollection is that from the beginning, herd immunity was not considered as a sensible option within the Welsh Government and there was from the early stages a direction to be cautious, act and mitigate that underpinned our approach throughout and the nature of decisions made by Ministers

Cooperation with other organisations outside of Wales

249. Four nations work occurred at various levels, across governments via Ministerial and civil service engagement and including the Chief Executives of the NHS for the four nations, CMOs, CNOs, Senior Public Health and policy professionals and clinical groups, with regular contact and teleconferences up to the end of April where required.

250. In my Statement, reference MB2-WG-01 I have outlined the arrangements put in place with the UK for PPE supplies, the National Testing Programme and Vaccine procurement. HSSG officials were engaged on these workstreams and as such established working relationships with their counterparts in the other nations to deliver these UK wide initiatives. In that statement I also outlined some of the more formal meetings such as COBR, Health MIGs and SAGE, which HSSG officials were also engaged in or supported Ministers at.

251. Maintaining a four nations approach, wherever appropriate, was important in the first phase response. This included the ability to: co-ordinate action in areas such as PPE supplies; share learning from the construction of additional bed capacity; share expectations for the NHS and care system; and the provision of mutual aid. It was important to work constructively with officials across all governments and systems to maintain consistency and share guidance, but we have also had to respond respectively to our own Ministerial expectations.

252. The four nations approach evolved over the course of the pandemic, particularly in areas like testing where Department for Health and Social Care (later the UK Health Security Agency) provided testing on behalf of all four nations, and on procurement of vaccines. These will be the subject of more detailed consideration by the Inquiry in subsequent modules.

Public health communications in Wales during the Covid-19 pandemic

253. The response to the Covid-19 pandemic was reliant on the people of Wales following the advice and guidance. The HSSG contributed to the development of key messages

and guidance for the public working closely alongside other teams in Welsh Government and Public Health Wales.

254. I remained mindful throughout the pandemic of the need for clear and transparent communication, and an honest conversation with the population of Wales to build public confidence and understanding. For this reason, I was involved in the communications approach to lead press conferences independently of Ministers, in recognition of my NHS Wales Chief Executive role. In total I led or was involved in 20 live press conferences, occasionally with the CMO(W) or Minister for Health and Social Services . The pattern involved me more at times of significant NHS pressure or public concern, and I hope acted as a trusted public and professional voice. These press conferences enabled me to convey the progress, as well as the challenges, across the range of issues faced by the NHS, and I hope helped to instil some trust and confidence in the NHS response and the way in which we exceptionally prepared to protect the people of Wales. I also undertook media interviews with UK and Wales-based media when requested at different stages of the pandemic.

255. Public Health Wales also conducted regular public engagement surveys, as well as a Health Impact Assessment of the 'Staying at Home and Social Distancing Policy' in Wales, both of which informed communication messages and future approaches.

256. The centrepiece of the Welsh Government campaign activity was the overarching "*Keep Wales Safe*" campaign which is detailed in my statement for M2B-WG-01. It enabled the Welsh Government to communicate Wales-specific issues in a way which was distinctive and differentiated from the UK Government's campaign activity.

257. The Inquiry has asked for me to set out the extent to which HSSG specifically (as opposed to Welsh Government generally) had a role in various aspects of communications and messaging. I am also asked to provide details of the commissioning and use of behavioural management throughout the pandemic.

258. I provide my response below but would state that I understand that Toby Mason has provided written evidence to the Inquiry. As Head of Strategic Communications for the Welsh Government he will be best placed to advise the Inquiry on questions relating to public health communications in Wales during the pandemic. Our HSSG structures were a formal part of the Welsh Government's communications approach and we were aligned under Toby Mason's leadership.

259. In relation to the steps the Welsh Government took to counter disinformation, I have detailed this in the corporate statement M2B-WG-01. Tackling disinformation and misinformation was undertaken throughout the pandemic guided by expert advice from a disinformation and misinformation specialist. I exhibit as **AGM2BHSSG01/58-INQ000281968** (dated 2 December 2020) the Welsh Government's communications plan for a Covid-19 myth busting campaign. Specific guidance was issued to schools to advise them on dealing with disinformation and misinformation being targeted towards schools and parents. I exhibit an example as **AGM2BHSSG01/59-INQ000282022** (dated 30 September 2021).

260. Communications around the vaccine were particularly mindful of the amount of disinformation and misinformation being circulated. The overall approach taken was to ensure people had access to authoritative information about the vaccine which presented facts around efficacy and safety. Working with Public Health Wales, significant efforts were made to promote accurate information to the Welsh population regarding the vaccine This included targeted work with communities where disinformation and misinformation was more prevalent, using trusted voices such as community leaders, faith groups or clinicians to deliver messages.

261. In relation to monitoring the effectiveness of different forms of communications, evaluating the effectiveness of Welsh Government communications is set out in the corporate statement M2B-WG-01. In relation to HSSG specifically all campaigns were evaluated throughout to enable us to track reach and opportunities to see messages, so media spend could be adjusted as and when necessary to ensure we were reaching our key audiences effectively. There were regular campaign updates and ongoing input from focus groups for example.

262. Regarding instances whereby the HSSG provided incorrect information to the public and how this was rectified or addressed, I am not aware of any instances of incorrect information being provided to the public by HSSG. I understand that Toby Mason has also provided a response on this matter more broadly in his written statement.

263. The Inquiry asks whether any different messaging by the UK Government (or devolved nations) impacted upon the clarity of messaging specific to Wales. I note that a high-level chronology of Welsh Government / UK Government communications interaction, divided into three general phases, has been set out in the corporate statement M2B-WG-01. There is also a section entitled 'challenge of different messaging across the

UK'. I understand that Toby Mason has also provided analysis in relation to the impact of different messaging in his written statement to the Inquiry.

264. In relation to whether public confidence was affected by any alleged breaches of rules and standards by Ministers, officials and advisors, and any other specific events or incidents that had a material impact on the maintenance of public confidence, the HSSG itself has not assessed this and is therefore not in a position to comment. As stated in the M2B-WG-01 statement there were no significant allegations of breaches of rules and standards made against Welsh Government Ministers or senior advisers during the pandemic. In respect of the maintenance of public confidence generally, I also refer the Inquiry to what is stated in the corporate statement M2B-WG-01.

265. The inquiry also asks for details of the commissioning and use of behavioural management throughout the pandemic, including any advice received in respect of public messaging and any proposed changes. I understand that Toby Mason has provided a detailed response to this in his written statement to the Inquiry. There is also a section which addresses this topic in the corporate statement M2B-WG-01 entitled 'use of behavioural insights'.

HSSG Recovery Planning

266. The Welsh Government recovery plan has been outlined in my statement M2B-WG-01. Members of the HSSG contributed to the broader recovery plans of the Welsh Government as set out in **AGM2BHSSG01/1-INQ000083221** through a number of forums, with successive frameworks for recovery accounting for the impact of the pandemic on health and social care services.

267. The leading forum through which members of HSSG contributed to wider recovery plans across the Welsh Government was the internal Continuity and Recovery Board established by Welsh Government. The Board, chaired by Jeremy Miles, Counsel General, was used to consider the complex and cross-cutting issues that arose as Wales emerged from the first wave of the Covid-19 pandemic and prepared for the end of the UK/EU Transition period. The interests of HSSG were represented by Albert Heaney, Deputy Director General HSS.

268. Within the HSSG itself, both the Covid-19 Planning and Response Group and the Stabilisation and Reconstruction Scoping Board were responsible for the development, implementation and assessment of recovery plans specific to health and social care. The HSSG Stabilisation and Reconstruction Scoping Board was established to focus

on the integrated health and social care response to Covid-19. This included understanding the impact of Covid 19 across all areas of the sector, analysing this impact, modelling for the future and ensuring that the most recent data and evidence was used to inform this work. This board was chaired by Sioned Rees.

269. To complement the Health and Social Care Stabilisation and Reconstruction Scoping Board, the Social Services and Integration Directorate (SSID) also established a Social Care Stabilisation and Reconstruction Board. This was a board of internal Welsh Government colleagues and key stakeholders from across the sector including ADSS Cymru, CIW, Regional Partnership Boards leads and third sector representatives. This board was chaired by Alistair Davey.

270. These Stabilisation and Reconstruction Boards oversaw the production of the 'Health and Social Care in Wales – Covid-19: Looking forward' plan published on 22 March 2021 (exhibited above as **AGM2BHSSG01/50-INQ000083250**). This was followed by a specific framework for social care on 22 July 2021, entitled 'Improving Health and Social Care (Covid-19 Looking Forward) Social Care Recovery Framework' exhibited as **AGM2BHSSG01/60-INQ000083254,** dated 22 July 2021). Both aligned with the Welsh Government's broader Continuity and Recovery Programme as outlined in my statement M2B-WG-01.

HSSG Lessons learned

271. My four Accountable Officer letters to the Permanent Secretary, set out in exhibits **AGM2BHSSG01/17-INQ000083231** (13 May 2020) **AGM2BHSSG01/18-INQ000083232** (29 September 2020) **AGM2BHSSG01/19-INQ000083233** (26 March 2021) and **AGM2BHSSG01/20- INQ000083234** (29 October 2021) provide my view at the time on how we learned from experience. They also show other important factors: for example, how we ensured assurance across the health sector by quarterly frameworks which specified how best to address particular risks; how we put administrative arrangements in place (such as the HSSG Planning and Response Group) which provided consistent briefing and communications across the Welsh public health sector; and how we worked with other arms of the state to help and support the pandemic response (for example, by drawing upon the advice and expertise of the Army's logistical specialists).

272. In addition to my own reflections while in the post of Director General HSS/Chief Executive NHS Wales, the HSSG conducted a number of exercises to reflect on the

lessons that could be learned from its role in the first and subsequent waves of the pandemic. The first comprehensive review of HSSG's role in the imposition of NPIs during the specified period was completed on 25 September 2020, with Samia Edmonds and David Goulding acting as lead officials for the review. The scope of the review was to identify learning from January to September 2020 in order to strengthen the HSSG's Covid response in the immediate term, as well as informing emergency planning arrangements more generally in the future.

273. The report resulted in 16 recommendations that were presented as strategic aims for consideration on how HSSG could continue to respond effectively to the Covid-19 response and make improvements to react to the second wave of Covid-19 and similar or concurrent incidents in the future. These recommendations spanned several key areas: incident response, policy development, communication and engagement, people and skills and governance and accountability (**AGM2BHSSG01/61-INQ000083255**, dated 25 September 2020, refers). In this report one of the issues raised anonymously by officials was the number of dataflows that were created which was felt caused confusion. For example, there were the following dashboards:

    i. Covid-19 dashboard created by Knowledge and Analytical Services;
    ii. Covid-19 situational Report;
    iii. Amakuni dashboard;
    iv. Public Health Wales surveillance dashboard;
    v. Public Health Wales recovery profile;
    vi. Cabinet office summary; and
    vii. TAC advice summary.

274. Not all of these dashboards were made public and it is not clear if this did cause any confusion outside of the Welsh Government. However to learn from this the report suggested data and information management processes should be reviewed to clarify what is needed and why via an information management group which includes all the key players. The Knowledge and Information Management (KIM) Profession in the Welsh Government is part of the wider the Government Knowledge and Information Management (GKIM) Profession. They work closely with colleagues in UK government, arm's length bodies, the Welsh public sector and other devolved

governments to share knowledge and benefit from being part of a UK Civil Service wide network.

275. Issues were also noted about comparability of UK data and Welsh data. As outlined in my statement M2B-WG-01 coherence of UK statistics was a feature throughout the pandemic and the early difficulties with data coherence was learned from ahead of the mass roll-out of vaccinations, with statisticians from each nation forming a working group in December 2020 to share plans and priorities and identify any issues with coherence early on. This rapidly improved understanding of the methods used by each nation. Glyn Jones, Chief Digital Officer, has provided written evidence to the Inquiry and further information on this topic and the differences in data requirements and engagement with UK departments will be appropriately addressed by him.

276. In June 2021, the Executive Directors Team Contingency Group agreed that there should be a second review of HSSG Covid response to follow on from a review of its response to Covid-19 that covered the period July 2020 - June 2021. The intention of the second review was to reflect upon response arrangements and experiences from the second wave, and to consider any changes or revisions in readiness for future waves, **AGM2BHSSG01/62-INQ000083259**, dated June 2021, refers. The HSSG continue to review the outcome of these reviews reporting back to the Executive Directors Team Contingency Group, the most recent reports being on the 18 May 2022 and 19 October 2022 (**AGM2BHSSG01/63-INQ000083261** (dated 18 May 2022) and **AGM2BHSSG01/64-INQ000083262** (dated 19 October 2022) refer).

Conclusion

277. I must stress that my statement does not seek to address the entirety of the HSSG activities during the specified period but deliberately focuses on those aspects of the HSSG work, the inputs and the outputs which would have been pertinent to informing the Welsh Government decision-making in respect of the imposition or non-imposition of NPIs and the general approach to the Covid-19 response in Wales.

278. I have very briefly touched on the wider work of this group, noting of course my lead role as Chief Executive of NHS Wales, but stress that the requirements on the HSSG through the specified period were relentless, as they were also for the wider health and social care sector. Our public services, notably in this context the NHS and care sector, responded in an exceptional and professional manner over a sustained period during the pandemic response and I would wish to recognise their contribution and positive

impact in Wales. The full scope of the HSSG activities will be examined in later modules by the Inquiry but for now I wish to articulate how proud and grateful I am of all those working across the HSSG who went above and beyond on many occasions to provide high quality policy and government business advice to myself as Director General HSS and directly to Ministers to protect the people of Wales.

Statement of Truth

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

Full name: Andrew Goodall

Position or office held: Permanent Secretary

Signed: **Personal Data**

Date: 29 September 2023