Witness Name: Andrew Goodall

Statement No: 5 (M2B)

Exhibits: M2B.WG.AG.01/001 - 071

Date: 8 January 2024

UK COVID-19 INQUIRY

MODULE 2B

FIFTH WITNESS STATEMENT OF DR ANDREW GOODALL

I, Andrew Goodall, will say as follows: -

I provide this statement in response to a request made by the Chair of the UK Covid-19 Public Inquiry ("the Inquiry") pursuant to Rule 9 of the Inquiry Rules 2006 dated 7 June 2023 and referenced M2B/WG/AG/01 ("the Request").

Introduction

1. The pandemic experience and our collective response to that experience represents the most challenging environment I have experienced in my career, and I know this will be true of everyone who played a role in delivering the pandemic preparation and response in Wales. This was a critical period for the NHS in supporting the people of Wales, at a time when the health system needed visible national support and leadership. Our care system, too, faced extraordinary challenges, necessitating enhanced oversight and an acceleration of the integration of our health and care systems which simultaneously recognised and respected the different organisation and stakeholder responsibilities in that system. It was also a critical time for government, which was required to take decisions that would impact on the day to day activities and behaviour of society at large. We were responding to a 1 in 100 year event that brought the world to a halt and - despite emergency planning preparations and our collective professional experience of running country-wide healthcare systems

- the coronavirus experience placed unprecedented, and hitherto unknown, demands on our health and social care services and required a response to be delivered within timescales that would have been unimaginable previously. I am immensely proud of, and grateful to, my colleagues in the Welsh Government and our partners across Wales, including notably of course the NHS and social care sector, whose dedication and commitment to keeping the people of Wales safe and delivering the services necessary to respond to the crisis was unwavering.

2. I have previously provided seven corporate statements to the Inquiry (see paragraphs 6 to 8 below), which describe the functions and infrastructure of the Welsh Government and how these were deployed to prepare for and respond to the pandemic. Each of those statements reflect, to a greater or lesser degree, my professional experience in the Welsh Government. While some of those statements were provided in my capacity as someone intimately involved with, and with oversight over, specific functional parts of our infrastructure (such as my statements on the Health and Social Services Group's and NHS Wales' response to the pandemic), others 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).

3. This is my first personal statement to the Inquiry. I provide it for the purpose of assisting the Inquiry to understand the way that individuals, who were involved in the response to the pandemic in Wales, worked and made decisions. It is my intention that this statement will be read in conjunction with my previous statements and understood in the context those statements provide. Consequently, I will not repeat evidence provided in those statements on the Welsh Government's structures and processes, except to the extent necessary to describe and explain my role in leading different elements of the system through the pandemic.

4. Through this statement, I hope to draw out some of the key themes of the pandemic response in Wales, particularly in the context of health and social care, and to provide a more personal reflection on the strengths of our system and how we can best learn lessons to both embed better ways of working going forwards and inform our preparations for the future. Principal among these themes are: -

4.1. Listening; ensuring that voices from across the system informed government decision making, and that the Welsh Government was able to respond quickly to the changing mood music of the system.

4.2. Collaboration; both within the Welsh Government and with our partners across the Welsh public sector, business, the third sector, and wider Welsh society, ensuring that plans and policies were co-designed whenever possible.

4.3. Partnership; partnership is an embedded way of working in Wales, and we were able to utilise our existing networks and relationships to facilitate the identification and mitigation of risk, the coordination and mobilisation of action, and regular engagement and support throughout the system.

4.4. Subsidiarity; using all available levers to influence, guide, support, and where necessary direct the system, while respecting the functions of, and expertise and experience in, its constituent parts, and having trust and confidence in their ability to deliver once decisions had been taken.

4.5. Intimacy; while this undoubtedly presented challenges, not least in terms of capacity, it also allowed us to work in a way that was genuinely collaborative, agile and responsive to a rapidly changing environment.

4.6. Evidence-based decision making; my focus was always on taking the right actions and decisions for Wales at the right time, for the purpose of protecting the population and saving lives. This required us to embrace data and evidence to support understanding and to inform decision making, to a significantly greater extent than was customary prior to the pandemic.

4.7. Transparency; clear and transparent communications, and an honest conversation with the population of Wales was essential to building and maintaining public confidence and understanding.

4.8. Governance; while decisions needed to be made urgently and at pace, both within the Welsh Government and by and for NHS Wales, I was always conscious of the need to embed our decision making in our governance

structures and processes, and clear in the governance requirements I set for the system.

5. From the very beginning of the pandemic, and throughout, my approach was always intended to focus on using the best available evidence to take the right actions and decisions for Wales at the right time, for the purpose of saving lives, protecting our communities, safeguarding those who are most vulnerable, promoting the welfare and wellbeing of the staff in our health and care systems, and planning and delivering capacity and services to respond to the crisis.

My previous statements

6. I have previously provided four statements to the Inquiry in connection with module 2B. My first statement (ref. **M2B/WG/01**) provided an overview of the Welsh Government, its organisation, structures, functions, governance, and decision-making processes, and was provided in my capacity as the Welsh Government's Permanent Secretary. My second statement (ref. **M2B/WG/WT/01**) was provided in my capacity as Principal Accounting Officer; it addressed the funding arrangements that applied to the Welsh Government. My third and fourth statements (refs. **M2B/HSSG/01** and **M2B/NHSW/01** respectively) addressed the role of the Welsh Government's Health and Social Services Group ("HSSG") in relation to the Welsh Government decision making on the imposition and relaxation of non-pharmaceutical interventions, and the structures and roles of NHS bodies in Wales (collectively referred to as "NHS Wales") and how they interacted with the Welsh Government during the pandemic. These statements were provided in my capacity as Director General of Health and Social Services ("Director General, HSS") and NHS Wales Chief Executive.

7. I have also provided three corporate statements to the Inquiry in connection with module 1. My first (ref. **M1/WG/01 - INQ000130469**) provided an overview of the Welsh Government's preparedness for whole-system civil emergencies, including resourcing, risk management and pandemic readiness, my second (ref. **M1/NHSWALES/01 - INQ000184901**) described NHS Wales's role in preparedness, and my third (ref. **M1/CSOCSAWALES/01 - INQ000197979**) explained how scientific, technical, and medical research, advice and support is organised across the Welsh Government.

8. I have also provided a statement to the inquiry in connection with module 3 (ref. **M3/WGO/01**) which addresses the healthcare decisions taken during the pandemic, the reasons for them, and their impact.

9. I outlined my qualifications and professional experience in those statements; consequently, I do not repeat them here.

This statement

10. This statement covers the period from 21 January 2020 to 30 May 2022 ("the pandemic"). During the first part of the pandemic, I held the roles of Director General, HSS and NHS Wales Chief Executive, having been appointed in June 2014. In September 2021, I was appointed to the role of Permanent Secretary; I took up this appointment on 1 November 2021. Consequently, I provide this statement in three parts: -

    10.1. In **Part A** I describe my work as Director General HSS and NHS Wales Chief Executive between 21 January 2020 and 31 October 2021. I explain my participation in, and responsibility for, the work of the Health and Social Services Group in informing and delivering the Welsh Government's response to the Covid-19 pandemic, with a particular focus on health and social care, and my role providing leadership, oversight, and assurance of the work of NHS Wales.

    10.2. In **Part B** I describe my role as Permanent Secretary and Principal Accounting Officer between 1 November 2021 and 30 May 2022. I explain my leadership of the Welsh Government Civil Service, my management of financial and other resources to deliver the policy and legislative priorities of the Welsh Government, and my role as principal adviser to the First Minister, the Cabinet, and the Welsh Ministers and their deputy ministers, during the later stages of the pandemic.

    10.3. In **Part C** I describe the lessons I have learned from my involvement in the Welsh Government's pandemic response, both through the many formal reviews and lessons learned exercises that I have participated in, and from my

own professional experiences during the pandemic and my reflections thereafter.

11. In view of the available time and the broad scope of the Request, the content of this statement is not based on a full examination of the many thousands of documents that are relevant to my work over the pandemic. Furthermore, the material that I have exhibited herein is not intended to provide a complete picture, rather this material is produced to illustrate key aspects of the work of the organisations that I led, and the advice I provided to decision makers in the Welsh Government. I hope it helps to inform the inquiry's understanding of my oversight of the healthcare system as NHS Wales Chief Executive and Director General, HSS and the advice that I provided to Ministers in that capacity and latterly as Permanent Secretary. I have sought at each stage to provide sufficient information to enable the Inquiry to return with specific requests for more detailed evidence and documentation in due course.

12. In preparing this statement I have relied upon advice and information from members of my senior team including Albert Heaney, Chief Social Care Officer; Judith Paget, Director General HSS; Samia Edmonds, Director of NHS Planning; Dame Shan Morgan, former Permanent Secretary; Frank Atherton, Chief Medical Officer for Wales; and Rob Orford, Chief Scientific Adviser for Health.

PART A

Director General, Health and Social Services and NHS Wales Chief Executive 21 January 2020 – 31 October 2021

The health and care system in Wales

13. The Welsh Government, through the Minister for Health and Social Services, is responsible for setting policy and standards to promote high quality, safe health and care services based on population need. NHS Wales, which comprises local health boards, NHS trusts, and special health authorities, is responsible for delivering healthcare services in Wales. These services are primarily delivered by local health boards, which act as both providers and commissioners of healthcare services in their areas, and which are responsible for the health of their local populations.

14. Each health organisation has its own legal duties to perform in respect of the population it serves, under the oversight of a Board, but in practical terms the NHS in Wales is line managed by the Welsh Government.

15. The Health and Social Services Group within the Welsh Government is responsible for exercising strategic leadership to, and oversight of, NHS Wales and the robust stewardship of NHS funds. The Group communicates Ministers' expectations of the various bodies that comprise NHS Wales in respect of planning and performance, and seeks assurance from those bodies through planning, delivery, and compliance frameworks. As the Chief Executive of, and Accounting Officer for, NHS Wales, I was personally responsible for discharging the authority of the Welsh Ministers over the NHS system. I was assisted by the chief executives of the bodies that make up the NHS in Wales, who were themselves accountable to me for their own organisations' performance in their roles as additional accounting officers.

16. The Health and Social Services Group also acts as a critical liaison point for the care sector in Wales, providing oversight of and support to those responsible for commissioning and providing care services, and supporting the Welsh Ministers to perform their policy oversight and expectations over the whole care system in Wales.

17. I explain the statutory framework that underpins the social care system in Wales in my statement ref. **M2B/HSSG/01** at paragraphs 39 to 47. I will not repeat that evidence here, except to say that statutory responsibility for delivering social care services is vested in Wales' twenty two local authorities under the Social Services and Well-being (Wales) Act 2014, as supplemented by the regulations, codes of practice, and statutory guidance made thereunder. Those local authorities are under a duty to provide social services to meet the needs of people in their area with a need for care and support, and to promote their wellbeing and the wellbeing of their carers. The Welsh Ministers may issue codes of practice and statutory guidance, which local authorities should act in accordance with when exercising their social care functions, and non-statutory guidance, to which local authorities should have due regard.

18. The Minister for Health and Social Services, and by extension the Health and Social Services Group's responsibility for social care is therefore strictly limited to matters of policy only; the operational delivery of care services in Wales is properly the responsibility of Welsh local authorities.

19. Again I have detailed this in my statement **M2B/HSSG/01**, but it is an important point to highlight, that the policy and recent legislation in Wales relating to the health and social care system has been designed to reflect the clear objective 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. Since joining the Welsh Government in 2014 I have personally developed, led and been responsible, as Director General HSS for this this move to integration which received ministerial sign off in the form of the 2018 plan, 'A Healthier Wales', which is our long-term plan for health and social care. In this statement I will refer to this plan, particularly in my concluding reflections, and how this plan framed our response to the pandemic for health and social care, ensuring co-production, innovation and collaboration.

The role of the Health and Social Services Group

20. The Health and Social Services Group has the following overarching responsibilities:

    20.1. Promoting, protecting, and improving the health and well-being of everyone in Wales, and leading efforts to reduce health inequalities.

    20.2. Making available a comprehensive, safe, effective, and sustainable national health service.

    20.3. Ensuring that high quality social services are available and increasingly joined up with health care and other services.

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

My role and responsibilities

21. As Director General, HSS during the pandemic I was personally responsible for: -

    21.1. Enabling inter-governmental decision making for health and social care.

21.2. Overseeing how health and social care policy decisions were made, communicated, and implemented.

21.3. The availability and use of data and evidence in decision making.

21.4. Preparedness, NHS capacity, and the ability to increase capacity and resilience.

21.5. Oversight of the pandemic response in all health settings, including in respect of infection prevention and control, triage, critical care capacity, patient discharge, the approach to palliative care, workforce testing, and inspections.

21.6. Responding to the impact of the pandemic on staff, staffing levels, and workforce wellbeing.

21.7. The national procurement and distribution of key equipment and supplies, including personal protective equipment ("PPE"), ventilators, and antivirals, noting existing responsibilities for equipment and supplies through our national shared service arrangements.

21.8. Shielding guidance, and the protection of the clinically vulnerable.

21.9. Contributing to evidence which informed decisions on the use of lockdowns and other non-pharmaceutical interventions such as social distancing and the use of face coverings, from a health and care perspective.

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

21.11. Overseeing the Welsh Government's public health functions, including through my line management of the Chief Medical Officer.

21.12. Supporting the Welsh Government's development of policy for social services and oversight of the care sector, including through my line management of Albert Heaney, Director of Social Services and Integration (until June 2021

when he was appointed to the role of Chief Social Care Officer for Wales) and Deputy Director General, Health and Social Services (from March 2020).

21.13. Supporting the directors in my team to discharge their responsibilities, including those picking up new responsibilities arising from the pandemic response, such as vaccination and Test, Trace, Protect.

22. To give an indication of the roles and responsibilities of the Director General, HSS and Chief Executive NHS Wales beyond the specific context of the Covid-19 pandemic, I produce here, as exhibit **M2B.WG.AG.01/001 - INQ000239578**, a copy of the job description for this role (dated 12 March 2023).

23. As NHS Wales Chief Executive I was accountable to the Minister for Health and Social Services and responsible for providing policy advice to Ministers, as well as exercising strategic leadership and management over NHS bodies in Wales. The responsibility for NHS Wales Chief Executive is vested in the Director General role and the powers passed down by Ministers, given that the NHS in Wales is not a statutory or corporate organisation of itself. This role is essentially an outward facing role, as the representative of NHS Wales, in contrast to the Director General, HSS role which is primarily an inward facing one.

24. I was also designated by the then Permanent Secretary, Dame Shan Morgan, as the Accounting Officer for the NHS in Wales, and personally responsible for the stewardship of funds for NHS Wales. I was assisted in that role by the chief executives of the different bodies that make up NHS Wales who, as additional accounting officers for health and social services themselves, were accountable to me for their respective organisations' financial management and performance. They were responsible for the leadership of their own organisations and discharge of their organisations' statutory responsibilities, in respect of local actions and implementation.

25. Authority to oversee the NHS in Wales is delegated from the Welsh Ministers, through the Director General, HSS to the chief executives of each NHS body, through the Accounting Officer and additional accounting officer delegations. In this way, the Director General discharges the authority of the Welsh Ministers on the NHS system and its constituent organisations.

26. In my experience, combining the roles of NHS Wales Chief Executive and Director General, HSS in one individual has been a real strength of the Welsh health system, which provided a vital bridge into government, both pre-pandemic and during the pandemic response. Rather than being unique to my own tenure, this approach has endured through three of my predecessors and my successor. Upon accepting the role of Permanent Secretary in September 2021, I carefully considered whether to retain this structure before recruiting my successor. I concluded that it remains that most appropriate approach for the benefit of both the health system and the Welsh Government's management of that system. It aligns with the approach taken in other devolved governments, notably Scotland, although it does differ from the position in England, in part because of the size and scale of the NHS and government functions in England, where the Department of Health and Social Care acts separately in its government function from NHS England which has been established as a statutory organisation in its own right.

27. I have commented before on my experience in Wales of working in an intimate and connected system and this experience was reflected in the way in which I balanced the Director General, HSS and NHS Wales Chief Executive roles during the pandemic. While each NHS organisation had their own statutory responsibilities for healthcare services, my dual role allowed me to simultaneously discharge a leadership and representative role for the NHS. It enabled me to set the collaborative and collegiate expectations for the system, requiring organisations to work across boundaries on behalf of the Welsh population's health, not just their own local communities. It also meant that an active, effective, and visible pattern of collective working was already embedded in the Welsh healthcare system, which supported our pandemic response. I was able to introduce a common approach and consistency across the system, rather than having to rely on organisations' own local assessments which would inevitably have taken time and resources at a time when critical decisions needed to be taken at pace on matters of public health and safety, such as the capacity assumptions that led to the establishment of field hospitals, templates for the vaccination programmes, operationalising system guidance, and the cessation of non-essential NHS activities to support pandemic preparation and response. While these things could have been achieved locally, within organisations, there would inevitably have been variation in policy and practice. Instead, we were able to achieve consensus and common ground across Wales, and a common experience for those who relied on our services during the pandemic.

28. Rather than filtering the systems' views through a separate Director General, as NHS Wales Chief Executive I was able to bring together intelligence from across the health system quickly and use it to good effect in my advice and support to Ministers, as a recognised voice of, and for, the NHS in government. I had the confidence of the NHS to discharge this role, in part because of the relationships that I had developed within the system over many years, including during my tenure as NHS Wales Chief Executive from 2014, and as a local health board chief executive from 2005. I think this gave additional credibility to assessments that I made on behalf of the NHS, and it also meant that there was a route by which advice to Ministers could be co-produced, and actions could be co-designed.

29. As an example of this, the significant decision to give the NHS time to plan and prepare for the pandemic as a priority, endorsed by the Minister and First Minister, resulted from discussions and exchanges that I had been having with NHS representatives. I produce here, as exhibit **M2B.WG.AG.01/002 – INQ000235895,** Ministerial Advice ref. MA/VG/1004/20 on the Covid-19 system risks framework. The actions set out in this framework, which were implemented immediately across the system, included the scaling back of all non-urgent outpatient appointments, day cases and elective admissions to allow for hospitals wards to be reconfigured to create additional critical care capacity and for the associate workforce to be redeployed and retrained.

30. These actions set a tone for the NHS in Wales to move into a different phase of pandemic preparedness, and was also a clear statement of intent and support for system preparation, at a time when the system was looking at the emerging experiences of other countries, most notably Italy and Spain, and Welsh modelling data provided by the technical advice cell ("TAC") indicated that Wales was perhaps only a few weeks behind in terms of the onset of peak infection and transmission. I produce here, as exhibit **M2B.WG.AG.01/003 - INQ000271443**, TAC's briefing on behavioural and social interventions, dated 11th March 2020. These actions were well received in the NHS, both by health organisations and clinical representatives, and helped build trust and confidence in the system that the Welsh Government would respond rapidly to their concerns and their advice, to ensure that NHS and social services were not overwhelmed, and would be able to deliver the services necessary to protect communities and save lives.

31. I felt that I was able to give a direct and clear NHS perspective on outlook and resilience in meetings with Ministers, including at Cabinet, and this was just one example.

32. I was always 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 relied upon as a trusted public voice of, and for, the NHS in media interviews and press conferences. I felt that this aligned with my experience as a national voice on health since 2014, and reflected ministers' trust and confidence in my ability to speak openly and honestly with the public on behalf of both the Welsh Government and NHS Wales. 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 Chief Medical Officer for Wales or the Minister for Health and Social Services. The pattern involved me more at times of significant NHS pressure or public concern, and I hope I 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. For example, following the Minister's decision on 13 March 2020 to scale back non-urgent outpatient and surgical care to allow the NHS to prepare for the pandemic (see paragraph 28 above), I attended a press conference with the First Minister and the Minister for Health and Services that same day to explain that decision.

33. I produce here, as exhibit **M2B.WG.AG.01/004 – INQ000350744**, a chronology of the press conferences that I led, or supported, and as exhibits **M2B.WG.AG.01/005 – INQ000350584**, **M2B.WG.AG.01/006 – INQ000222844**, and **M2B.WG.AG.01/007 – INQ000350587**, example transcripts. These transcripts are particularly personal to me, as my practice throughout the pandemic was to prepare my own press transcripts, in my own words.

34. While I hope that my personal leadership style and relationships have assisted to some degree, it was the structures in place (including the dual Director General, HSS and

NHS Wales Chief Executive role) that brought the health system's experience, learning, advice, and concerns closer to government, facilitating better decision making that was fully informed by local risks, requirements, and capacity.

35. My broader Director General role, principally as a member of the Permanent Secretary's senior team, also meant that I was closely connected with the actions and activities of government in response to the pandemic across a wide range of policy areas, and I was able to share that broader perspective with the NHS when needed. This was particularly important as the Welsh Government, and the First Minster and Cabinet in particular, needed to balance many potential harms (which went beyond purely public health considerations), when making decisions for Wales, as I will explain later in this statement. My involvement in the corporate and shared decision-making across government, beyond the line management of the NHS, allowed me to explain and contextualise those decisions with conviction and credibility.

36. My support to Ministers required me to act as the expert on, and advocate for, the NHS around the table, using both system feedback and data (discussed further below) to inform and advise decision makers. Meanwhile, my Director General responsibilities still required me to oversee the budget arrangements in a volatile environment, ensure policy advice was available to Ministers, and to oversee new and additional Covid-19 related responsibilities such as the vaccination programme and the Test, Trace, Protect system. I felt this strengthened and enhanced the NHS' status and response, gave clarity to the system, and made me effective in my role around Ministers.

37. As Director General HSS, I was also responsible for overseeing the further integration of health and social care in Wales (the legislative and policy context for which is explained in my corporate statement ref. **M2B/HSSG/01** at paragraphs 40 to 44). In the context of the pandemic, I provided oversight of the work that Albert Heaney and his team undertook to coordinate the Covid-19 response across the care sector, to develop Covid-specific policies for care settings, and to support the commissioners and providers of care services, I provided emergency funding to the care sector, for example through the Integrated Care Fund, and I used my leadership position within NHS Wales to set expectations for cooperation and collaboration between providers of health and care services at a local and regional level.

38. I have always been clear that I discharge both the Director General, HSS and NHS Wales Chief Executive roles, but they are not always equal in function or time discharged. While I have always prided myself on being corporately visible and part of the Welsh Government's senior team, attending meetings of the Board and Executive Committees and leading on internal civil service areas when needed, there has always been a greater need for me to commit time to the management and oversight of the NHS, as without that commitment I could not have successfully discharged my role as system leader. My main role during the pandemic response, whilst always being available to advise and support Ministers, was in the leadership and oversight of the NHS, including by providing strategic direction on key issues, promoting consistency through our frameworks and, when necessary, making national decisions on behalf of the system (for example, to address acute capacity needs in the NHS Wales). In many respects, due to the intense activity during the pandemic response, most notably during the acute phase of each wave, the available time would inevitably flex and expand into out of hours to accommodate the urgency of the decision and the need to lead the system and to advise Ministers simultaneously.

39. Whilst the questions that the Request poses centre around my own role, there was an emphasis on collaboration, co-design and accessing external system expertise across my team. It is therefore impossible to answer those questions fully without providing some wider context on how we worked, as a team and with others.

40. The Welsh Government's initial response to the risks arising from the emergence of Covid-19 started as a health-led response, with Cabinet oversight and support, notably in respect of the Coronavirus Action Plan[1] and the development of the 21-day review process (described further below, and in detail in my statement ref. **M2B/HSSG/01**[2]). My role was to provide leadership, advice, and support to the NHS and to discharge the Director General responsibilities, with a greater proportion of my time being committed to the NHS role. Others supported the decision-making cycle of the Cabinet and the approach to decisions that impacted on the broader Wales population, notably

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[1] See paragraphs 220 to 225 of my statement ref. **M2B/WG/01** for a detailed description of the development of the Coronavirus Action Plan through the Pandemic Period and each iteration of the plan thereto exhibited.
[2] See paragraphs 137 to 230 of my statement ref. **M2B/HSSG/01** for a detailed chronology of the 21 day reviews undertaken by the Welsh Government between 16 April 2020 and 23 May 2022, including the advice I provided to the Welsh Ministers on NHS and social care capacity and resilience which informed those reviews.

lockdown and the use of other non-pharmaceutical interventions, although I continued to participate in these discussions and provide advice when needed. This cycle was initially overseen by the Director of Local Government and Civil Contingencies, Reg Kilpatrick and his team. The need for a more senior level of coordination on these non-health issues was formally recognised in September 2020, with the creation of a new Director General role with responsibility for Covid Coordination. I welcomed this move as it demonstrated that the response was broader than health, and it reflected the way in which the organisation had responded over the previous months, with clear decision-making within Cabinet, whilst the First Minister and Minister for Health and Social Services continued to have prominent public roles leading the response.

41. It is worth saying that irrespective of the balance I struck between my Director General and NHS Wales Chief Executive roles and how that balance waxed and waned in response to the changing environment, there was a significant prioritisation of time and resources within the Health and Social Services Group to Covid-19 preparation and response. Pulse staff surveys showed that up to 80% of Welsh Government staff felt that their day-to-day responsibilities had changed to prioritise Covid-19 related work during the response (and I produce a copy of that survey here as exhibit **M2B.WG.AG.01/008 – INQ000350543**). This was true of the broader organisation but was particularly visible in the Health and Social Services Group during the initial phase of the pandemic response.

42. As the Health and Social Services Group's role in delivering the pandemic response expanded, including as a result of the establishment of new systems and operations like the vaccination programme and Test, Trace, Protect, the need to add additional resource, including transfers of additional staff, into the Health and Social Services Group was recognised. However, it is important to understand that the Health and Social Services Group was an extremely compact organisation, with only approximately 400 full time equivalent staff in post at the start of the Pandemic period, excluding the CAFCASS family justice service. This compact capacity meant that cross-Welsh Government working with other teams and colleagues was critical. It also required me to maximise the utilisation of NHS expertise out with the Welsh Government and across the wider system, through my role as NHS Wales Chief Executive. This collaborative approach extended beyond simply NHS Wales and to other partner agencies, stakeholders and representative groups also.

43. I was, within this role, also a member of the corporate senior team, working alongside other directors general and directors and supporting the Permanent Secretary, Dame Shan Morgan, in her role and oversight over the organisation. I worked very well with Shan, and I appreciated her trust in me. I felt that she had confidence in me and my ability to manage the health response, but she was very supportive and was always available to talk through emerging risk and issues, and priorities, and to provide a steer based on her broader role managing the whole Welsh Government's response. Her personal and professional support was particularly helpful following my appointment as her successor, and during my transition to the role of Permanent Secretary.

My team

44. As the Director General, HSS, and the senior civil servant in the Health and Social Services Group, it was my responsibility to set the direction for the pandemic response in health and social services, our priorities and the outcomes we needed to achieve, and to define the structures, systems and resources required to deliver those outcomes.

45. While I set the overarching strategy and expectations, I delegated responsibility for leading different aspects of the pandemic response to my directors and deputy directors and the teams they led. I sought to give them the space and authority to take decisions and to provide unbiased evidence-led advice to Ministers in their own areas of responsibility, while providing encouragement, support, coaching, and direction as necessary, and holding them accountable for delivery.

46. As I explained in paragraph 41, the Health and Social Services group was small. This compact structure and intimacy facilitated a collaborative working culture where directorates, teams and individuals working flexibly across the Group to share knowledge and understanding, and to develop coordinated responses to cross-cutting risks and issues. This meant that while I may have delegated responsibility for managing particular aspects of pandemic preparation and response to members of my team, they worked closely together, and with me, to ensure that our response was effectively coordinated across health and social care.

47. The structures we established, both prior to and during the pandemic, provided a governance structure within which people were empowered to take the right decisions

at the right time for the people of Wales. However, informal communication and collaboration across the Group was also critical to delivering the pandemic response, and I sought to foster a collaborative culture in which openness, approachability, and challenge were encouraged at all levels.

48. Key among the individuals who supported me in my role as Director General, HSS and NHS Wales Chief Executive during the pandemic were: -

Deputy Director General of Health and Social Services / Director of Social Services and Integration

49. At the start of the pandemic, Albert Heaney held the role of Director of Social Services and Integration. In that role, Albert was the principal policy adviser to the Welsh Ministers on adult and children's social care, and responsible for discharging the Welsh Ministers' oversight of the care sector in Wales.

50. In recognition of the importance of the care sector in achieving the Welsh Ministers' objective of saving lives and keeping people safe, and of Albert's professional experience, expertise and established relationships in that sector, in March 2020 I promoted Albert to the role of Deputy Director General for Health and Social Services (in addition to his responsibilities leading the Social Services Directorate). This had the dual benefit of elevating the care sector's voice at the heart of government decision-making and freeing up more of my time to focus on the demands placed on me as Chief Executive NHS Wales.

51. Albert played an important convening and collaboration role for the sector, bringing together commissioners, providers, and wider stakeholders at a national level and helping to drive the further integration of health and social care, while respecting the statutory responsibilities and structures for the operational delivery of care services in Wales (which are described in more detail in Albert's statement to the Inquiry, ref. **M2B/CSSO/01**).

52. The Social Services Directorate, led by Albert, had well established stakeholder relationships and communications channels with the statutory directors of social services in local authorities, and with a wide range of other stakeholders and partners in the care sector, including providers of social services, regulators, and in the

voluntary and community sector. Albert supplemented these existing structures by establishing regular meetings with local authority directors of social services, with the Older People's Commissioner, and with representatives of social care providers, early in the pandemic. This created a clear collaborative intent to work together and use feedback and expertise from across the sector to guide the Welsh Ministers' decision-making.

53. Albert and I met regularly during the pandemic, through our participation in a range of formal and informal committees and forums. Albert and I were both members of the HSS Planning and Response Group (see paragraphs 180 to 187 of this statement), and Albert would attend meetings of my Executive Directors Team (see paragraphs 172 to 179 of this statement) and the Senior Officers Group within HSSG (see paragraph 186 of this statement). Albert Heaney and I also met regularly on a one-to-one basis, to discuss his work as Deputy Director General, HSS, the work of his Directorate, and his leadership of, and support for, the whole care system.

54. Albert provided significant advice to the First Minister, the Cabinet, senior officials in the Welsh Government and to me on preparation and response within the care system. His experience in the care sector over many decades, and the visible leadership role he played across the whole system, enabled him to act as an important bridge between the Welsh Government and local authorities and service providers, to understand and explain emerging risks and issues in the system, and to provide clear advice to Ministers on policy and other support for the sector throughout the pandemic. Albert also joined me at Cabinet meetings at key moments when the challenges faced by the care sector were more visible or urgent, ensuring that Ministers were able to draw upon his experience and expertise when needed to inform their decision making. Albert was a powerful voice for the care sector in Government.

55. Albert worked closely with colleagues across the Health and Social Services Group such as the Chief Medical Officer (see paragraphs 73 to 87 below), the Chief Scientific Adviser for Health (see paragraphs 93 to 101 below), and the Chief Nursing Officer, (see paragraphs 102 to 111 below) and with teams across the Welsh Government to ensure that Ministers received balanced guidance and advice that reflected a range of policy responsibilities and priorities.

56. Albert also played a prominent and important role supporting the Minister and Deputy Minister for Health and Social Services in their meetings with external stakeholders.

57. In June 2021, Albert was appointed to the newly created role of Chief Social Care Officer for Wales, allowing him to provide a stronger, and more independent voice for the care sector in government.

Deputy Chief Executive NHS Wales

58. Prior to the pandemic, Simon Dean was seconded to Betsi Cadwaladr University Health Board, and Alex Howells was seconded to the role of interim Deputy NHS Wales Chief Executive from 31 March to 25 June 2020. Alex was the Chief Executive of Health Education and Improvement Wales (a special health authority, and part of NHS Wales), and she agreed to take up the interim role as Deputy Chief Executive NHS Wales alongside her substantive role at Health Education and Improvement Wales.

59. Alex provided an important reference point in the NHS in Wales, and acted as a bridge to the health service on a range of operational and risks areas. She had a significant role in producing the first NHS Wales Covid-19 Operating Framework (which I produce here as exhibit **M2B.WG.AG.01/009 - INQ000182468**). This framework, set initially for the first quarter of the 2020/21 financial year, continued to be used and updated throughout the pandemic. It was developed with the system and was reflective of NHS Wales' expectations during the early part of the pandemic and the pressures it was facing.

60. In my opinion, Alex's appointment enhanced two-way communication with NHS colleagues and organisations across Wales and significantly supported the Welsh Government's response to the first wave of Covid-19.

61. Simon Dean returned to his substantive role in the Welsh Government on 26 June 2020. In addition to supporting me in my role as Chief Executive NHS Wales by assisting with oversight of the NHS in Wales, Simon also led on the NHS Wales Covid-19 Operating Framework and on specific operational issues, like the procurement and supply of personal protective equipment.

62. I understand that Alex and Simon have both provided statements to the Inquiry, refs. **M2B/WG/AH/01** and **M2B/NHSW/SD/01** respectively.

Director of NHS Planning

63. Samia Edmonds (also known as Samia Saeed-Edmonds) played a key role supporting my need for national structures and response across both internal and external stakeholders. These structures were established at pace, but continued to develop and adapt in line with the development of the coronavirus, its progression, and our response to that.

64. Samia was instrumental in establishing the HSS Planning and Response Group (see paragraphs 180 to 187 of this statement) on 20 February 2020. This group brought together strategic representatives from the NHS Wales and social services and officials from the Health and Social Services Group on a regular basis (at least twice weekly and more often when needed), providing a pivotal outward facing mechanism for engagement with NHS organisations and social care providers, and supporting my need for national structures and response across internal and external stakeholders. Samia's work in this area provided professional leadership and assurance to me in my role as Director General, HSS and Chief Executive NHS Wales.

65. Samia had responsibility, along with Andrew Sallows (see paragraphs 67 to 72 below), for oversight of capacity and demand across NHS Wales. From early March 2020, she and Andrew were in regular contact with local health boards. Daily situation reports ("SitReps") were put in place to establish bed capacity and occupancy in each health board's area. These SitReps meant that I had excellent visibility across the whole system, and was able to follow through emerging risks and issues with conversations with different parts of the system at important moments.

66. The modelling work that was done at this very early stage of the pandemic response remained a consistent part of our monitoring of pressures across the system during the whole pandemic and meant that we were able to project, with a high degree of accuracy, the impact of prospective decisions on the system and its capacity to adapt, respond to, and mitigate risks and pressures. These SitReps informed my daily updates to Ministers and my reports to Cabinet, ensuring that Ministers were fully appraised of the system's capacity and resilience at all decision points.

67. I understand that Samia has provided her own statement to the Inquiry, ref. **M2B/WG/SEE/01**, in which she describes her role in establishing the HSS Planning and Response Group and the Planning and Response Cell, providing advice to Ministers on specific issues and operational updates on capacity and resilience in NHS Wales as part of the 21 day review process.

Delivery Programme Director for the NHS

68. Andrew Sallows, Delivery Programme Director for the NHS, was the operational equivalent of Samia Edmonds (who led on the planning side).

69. Andrew was instrumental in gathering evidence on the practical and operational experience across the system and channelling this, through me, to ministers.

70. Andrew led on the NHS operational context and networks, NHS capacity assessments and data modelling, and accessing data to understand current pressures and their impacts on future outcomes.

71. He frequently deputised for me within the NHS context, and often played a key role in my absence to update on NHS status and issues with other partners and stakeholders, including confidently doing so at the request of the Minister for Health and Social Services and the First Minister whenever needed.

72. He also remained very close to NHS operational voices and military planners (see paragraphs 236 to 241 of this statement).

73. Andrew was a critical member of my team and a key adviser to me in my role as NHS Wales Chief Executive.

Chief Medical Officer for Wales

74. The Chief Medical Officer for Wales plays a vital role in the healthcare system in Wales, providing independent advice to ministers on matters of public health and acting as an advocate for better health for the people of Wales. The Chief Medical Officer for Wales also holds the position of Medical Director, NHS Wales, working closely with the

medical directors in each of the local health boards to support the delivery of high-quality clinical services.

75. Frank Atherton held the role of Chief Medical Officer for Wales throughout the pandemic. He reported directly to me, as Director General, HSS and advised and supported me in my role as NHS Wales Chief Executive.

76. Alongside his role as the Chief Medical Officer for Wales, Frank Atherton was also the Director of Population Health, responsible for leading the Population Health Directorate, which was the largest policy division within the Health and Social Services Group and responsible for health protection, health improvement for the Welsh population, health and care research, and health service quality and effectiveness.

77. Frank was supported by a strong clinical team that included the Deputy Chief Medical Officer for Wales (see paragraphs 88 to 92 below), the Senior Professional Advisor to the Chief Medical Officer for Wales, and the Chief Nursing Officer (see paragraphs 102 to 111 below), and their respective teams.

78. Frank Atherton and I regularly attended Cabinet meetings together to brief the First Minister and ministers (see paragraphs 119 to 128 of this statement). Frank and I would also be called upon to provide advice and support to the First Minister, the Minister and Deputy Minister for Health and Social Services, and other ministers when needed.

79. Frank had a more prominent role in COBR (see my corporate statement ref. **M2B/WG/01** at paragraphs 179 to 183) and Ministerial Implementation Group meetings (see paragraphs 187 to 191 of that statement) noting their focus on policy and his advisory role on those, but I would also attend the Healthcare Ministerial Implementation Group meetings when needed.

80. Frank and I were both members of ExCovid (see paragraphs 167 to 171 of this statement), and Frank attended the HSSG Senior Officers Group meetings (see paragraph 186 of this statement) and meetings of my Executive Directors Team (see paragraphs 172 to 179 of this statement).

81. Frank and I also shared oversight of the work of the HSS Planning and Response Group (see paragraphs 180 to 187 of this statement) in recognition of our discrete but closely connected responsibilities, and Frank would attend my meetings with Chief Executives in NHS Wales (see paragraphs 219 to 229 of this statement) and the NHS Wales Executive Board (see paragraphs 209 to 213 of this statement).

82. Frank and I met regularly on a one-to-one basis, to discuss public health both in the context of the Welsh Government's response to the pandemic and more generally, and the work of the Population Health Directorate. Our contact was regular, often daily, depending on the wave and phase of the pandemic response. We also shared some press conferences together presenting a balanced commentary across system, professional and public health issues associated with the pandemic.

83. Frank had significant autonomy and was able to make and implement system decisions as the professional medical leader for NHS Wales and in accordance with his primary public health responsibilities. On occasion, when the additional authority that came from my role as Chief Executive NHS Wales was needed, I would also correspond with the system, particularly with the chief executives of the bodies that comprised NHS Wales, on specific requirements and policy decisions. Frank and I would liaise closely at these times, and coordinate our communications to the system for the purpose of clarity and consistency.

84. Frank and I also worked closely together to support the Senedd's understanding and scrutiny during the pandemic. I was directly accountable to the Senedd's Public Accounts Committee as Accounting Officer for NHS Wales, and I would routinely attend committee meetings on specific issues and for briefings in my role as Director General, HSS and NHS Wales Chief Executive. This continued throughout the pandemic. While the normal practice prior to the pandemic was that officials would only attend subject committees alongside ministers in a supporting role, these business as usual arrangements were supplemented during the pandemic as it felt important to offer something different to Members of the Senedd based on the steer received from, and with the support of, ministers. During the pandemic, Frank, I, and other officials from the Health and Social Services Group would often attend meetings of the Health and Social Services Committee with ministers. Due to the exceptional circumstances of the pandemic, we also attended meetings of this Committee, when required and by invitation, both in public and private to update Members of the Senedd and to respond

to their questions on the pandemic's status and the actions being taken to respond to it.

85. We also supported, at the request of the First Minister, routine briefings that were put in place between the First Minister and other party leaders, to offer an open and personal view of developments and actions and to respond to their own questions in an informal remote meeting.

86. We worked very closely together, and provided mutual support to one another in key discussions, but required actions were always directed to the appropriate decision point, whether to me in respect of the NHS, or with Ministers in respect of policy matters.

87. I was always available to Frank when needed, as his line manager, and I was grateful to have had such an experienced, values-led, internationally recognised, public health expert in the role of Chief Medical Officer for Wales. I would like to personally acknowledge the highly effective role Frank played in protecting Wales and advising Ministers throughout the pandemic response. His advice was trusted and received with confidence by Ministers, although they, of course, had to assess and make their own decisions having carefully considered all the advice available to them.

88. I would refer the Inquiry to my previous statement ref. **M1/CMOCSAWALES/01-INQ000197979** which provides an overview of how scientific, technical and medical research, advice and support is organised across the Welsh Government, as well as Frank Atherton's statements to the Inquiry, ref. **M1/ATHERTON/01 – INQ000184902** and **M2B/CMO/01** which provide more information about Frank's role as the Chief Medical Officer for Wales and Director for Population Health.

Deputy Chief Medical Officer for Wales

89. Chris Jones, Deputy Chief Medical Officer for Wales, provided significant support to me and to the Chief Medical Officer for Wales, Frank Atherton.

90. In addition to deputising for the Chief Medical Officer for Wales, Chris co-chaired the Acute Secondary Care Sub-group of the HSS Planning and Response Group (see 180

to 187 of this statement), and the Nosocomial Transmission Group (see paragraphs 200 to 203 of this statement).

91. As co-Chair of the Acute Secondary Care Sub-group, Chris provided leadership and oversight of the delivery of healthcare services in acute secondary care settings throughout the pandemic. This sub-group was tasked with freeing up as much capacity as possible in hospitals for those patients most severely affected by Covid-19, while maintaining services for other patients with life threatening conditions. This was a difficult balance to strike, and the work had to be delivered at pace, and I am grateful to Chris for the considered manner in which he supported the NHS in Wales, working closely with the system and particularly with the NHS Wales co-Chair of the sub-group, Steve Curry, to co-design and co-develop critical policies, procedures and pathways.

92. As co-Chair of the Nosocomial Transmission Group together with the Chief Nursing Officer for Wales (see paragraphs 102 to 111 of this statement), Chris was responsible for developing and overseeing the preparation and implementation of infection prevention and control measures to minimise nosocomial transmission of Covid-19 (transmission in healthcare settings). Strict adherence to these measures was necessary to prevent transmission between patients, healthcare workers, and visitors, particularly when community transmission rates peaked, and Chris played a key role in providing leadership to the system on this important issue.

93. I understand that Chris has provided his own statement to the Inquiry, ref. **M2B/WG/CJ1/01**.

Chief Scientific Adviser for Health

94. The Chief Scientific Adviser for Health is one of the principal sources of advice to the Health and Social Services Group, including myself, on health sciences and related services. The Chief Scientific Adviser for Health also provides clinical leadership to promote the continuing cost-effective development and transformation of services in Wales within a complex, dynamic and changing healthcare environment.

95. Rob Orford held the role of Chief Scientific Adviser for Health throughout the pandemic. He reported directly to Frank Atherton, the Chief Medical Officer for Wales (see paragraphs 73 to 87 of this statement).

96. Rob co-chaired both the Technical Advisory Cell ("TAC") and the Technical Advisory Group ("TAG") (see paragraphs 191 to 199 of this statement). Rob also participated in the TAG / TAC Steering Group which was established to enable us to effectively prioritise the scientific and technical work that Rob led with Fliss Bennee (see paragraph 116.1 of this statement). Rob also attended SAGE meetings on behalf of the Chief Medical Officer for Wales and the Welsh Government during the pandemic.

97. I received frequent reports, updates, and advice from the Technical Advisory Group and the Technical Advisory Cell, and these were mainly channelled through Rob. Principal among these were: -

97.1. the TAC summary: a synthesis of the latest Covid-19 surveillance and epidemiological data, modelling updates, as well as summaries of and links to high quality research on Covid-19.

97.2. the Covid-19 situational report ("SitRep"): a concise summary of Covid-19 situational awareness information for Wales, against agreed indicators.

97.3. the 21-day review report: advice to the Cabinet which informed the 21-day review process.

98. The Technical Advisory Cell also provided and interpreted scientific evidence and advice from a range of sources, including SAGE, international sources, Public Health Wales, and various consortia and sub-groups for the Welsh context. Its specialists and experts provided invaluable advice and expertise, which in turn informed my assessments of NHS capacity and resilience.

99. While the Chief Medical Officer for Wales had a specific advisory role to Cabinet within decision-making processes and the 21 day review cycle, the broader professional advice provided by the Chief Scientific Adviser for Health was openly and transparently available for Ministers at Cabinet, individually, and in informal briefings and during Ministerial calls. The wider Health and Social Services Group also benefited from the Chief Scientific Adviser for Health's advice and expertise, which informed policy development and the Welsh Government's operational response. In my opinion, the evidence and advice produced by TAG and TAC, led and enabled by Rob and Fliss, was fundamental to providing professional and balanced advice for Ministers, enabling

them to make evidence based decisions on the best course of action at each particular moment.

100. I met with Rob regularly throughout the pandemic, both through the formal structures outlined further below in this statement, and more informally and one-to-one.

101. I would like to take this opportunity to personally acknowledge the way in which Rob readily and willingly stepped up to lead the technical and scientific aspects of the Welsh Government's pandemic preparations and response. He, together with Fliss Bennee, played a leading role in ensuring that the Welsh Ministers had access to the best available evidence to inform their decision making, and that robust data and evidence drove the actions we were taking within the Health and Social Services Group and across the Welsh Government. I, ministers, and officials across the Welsh Government benefitted enormously from Rob's analysis, insight, and advice and I was grateful for his leadership and the professional and committed way in which he discharged his role throughout the pandemic.

102. Understandably, given the health focus of both of our roles, I relied heavily on Rob Orford, and had less professional contact with the Chief Scientific Officer for Wales, Peter Halligan. However, as Rob at times found it difficult to secure the same access to UK-wide networks, UK-level intelligence and the benefits of collaboration and information exchanges with the other UK Chief Scientific Advisers that Peter benefitted from, in terms of future health pandemic planning, I believe that it is vital that the significance of the Chief Scientific Adviser for Health's role in Wales is formally recognised and embedded in UK-level preparation and response structures.

Chief Nursing Officer Wales

103. The Chief Nursing Officer for Wales is the head of the nursing and midwifery professions in Wales and as such sets the professional agenda and future direction for these professions. The Chief Nursing Officer also acts as a sponsor and advocate for patient voice and clinical quality.

104. The Chief Nursing Officer for Wales is a senior adviser to the Welsh Ministers on all matters relating to nursing and midwifery education and practice, and leads on policy in relation to maternity and breast-feeding services, quality, and safety of care in NHS

Wales (in tandem with the Chief Medical Officer for Wales), and promoting the health of learning-disabled people. The Chief Nursing Officer for Wales also contributes to policy development across the wider Health and Social Services Group.

105. The Chief Nursing Officer for Wales performs a significant professional and leadership role in the Welsh Government's oversight of NHS bodies in Wales. The Chief Nursing Officer leads on delivery of certain aspects of the Welsh Government's strategy for health and social services, set out in 'A Healthier Wales', such as quality and safety, patient experience and driving improvements in maternity and neonatal services, as well as contributing to the collective effort to deliver its wider objectives. I produce here, as exhibit **M2B.WG.AG.01/010 – INQ000066130**, A Healthier Wales.

106. The Chief Nursing Officer for Wales works collaborating with senior leaders across NHS Wales and with the chief nursing officers for the UK and devolved governments, UK government departments, the Council of Deans Wales, the Nursing & Midwifery Council, other regulators and professional bodies, the trades unions, and the Welsh Government's service delivery partners to ensure and assure the delivery of the Welsh Government's policy priorities for the nursing and midwifery professions.

107. Professor Jean White held the role of Chief Nursing Officer for Wales at the commencement of the pandemic and until her retirement on 5 April 2021. She was succeeded by Gareth Howells, who was appointed to the role on an interim basis, and then by Sue Tranka who took up the role of Chief Nursing Officer for Wales substantively from 31 August 2021. The Chief Nursing Officer for Wales reported directly to me, as Director General, NHS Wales and supported and advised me in my role as NHS Wales Chief Executive.

108. Given the role that the Chief Nursing Officer plays in the Welsh Government's professional oversight of care within the NHS in Wales, their voice was always important in developing and shaping the Welsh Government's pandemic response. The Chief Nursing Officer for Wales guided key areas of national and professional policy and advice with support from teams within and outside the Welsh Government and worked with colleagues across the UK also to align and support professional standards and practice in a pandemic environment.

109. The Chief Nursing Officer, including through their role co-chairing the Nosocomial Transmission Group (see paragraphs 102 to 111 of this statement) with the Deputy Chief Medical Officer for Wales (see paragraphs 88 to 92 of this statement), produced professional advice and guidance both for the health system and practitioners, particularly on infection prevention and control but across a wide range of professional standards and practices.

110. The Chief Nursing Officer was also a significant contributor to system wide advice, such as the Operating Framework for NHS Wales. When necessary, I was also able to use my authority as Chief Executive NHS Wales to reinforce key messages to the system, and to contextualise professional guidance and advice from a system-wide perspective. However, in my experience the Chief Nursing Officer was really critical in leading the professional voice and ensuring a national response to critical aspects of the system's pandemic response, even in areas where matters of implementation had to be left to individual NHS organisations (albeit within the context set by the Welsh Government's national framework).

111. I also relied on the Chief Nursing Officer to inform my assessments of NHS capacity and resilience, given that they were in routine contact with professional bodies, groups, and trades unions across Wales and provide valuable insight into the demands and pressures on different parts of the health system in Wales and, in particular, nursing and midwifery professionals across Wales.

112. I had regular contact with the Chief Nursing Officer throughout the pandemic, through formal structures like my Executive Directors Team meetings and the NHS Wales Leadership Board, and through our joint participation in a variety of programme meetings and arrangements. The Chief Nursing Officer and I also met regularly on a one-to-one basis, to discuss the work of the Nursing Directorate, both in respect of the Welsh Government's pandemic response and more generally, and the performance of NHS bodies in Wales and delivery of the objectives contained in A Healthier Wales.

Chief Pharmaceutical Officer for Wales

113. The Chief Pharmaceutical Officer for Wales, Andrew Evans, leads on all aspects of pharmacy and medicines related policy and practice, including medicines-related regulation, policy development, and improvements in pharmacy practice. Andrew

provides professional leadership and support to the pharmaceutical profession in Wales, including community pharmacists, and works collaboratively with pharmacists working within both local health boards and NHS trusts in Wales.

114. Andrew leads the Pharmacy and Prescribing Branch, which is part of the Primary Care Division which in turn is part of the Directorate for Health Policy. He reports to the Director of Primary Care and Mental Health but is accountable to the Chief Medical Officer for Wales and ultimately the Minister for Health and Social Services. Andrew is supported by the Deputy Chief Pharmaceutical Officer for Wales, but routinely draws upon relevant professional expertise within Public Health Wales.

115. While Andrew was line managed by the Chief Medical Officer for Wales, I nevertheless had regular contact with Andrew throughout the pandemic. In the early phase of the Welsh Government's pandemic preparation and response, our conversations tended to focus on resilience actions for NHS Wales, notably in the context of assuring medication supplies, including oxygen capacity. Over time, my work with Andrew focussed more on Andrew's role in advising upon and assuring delivery of the vaccination programme in Wales. Andrew was involved in many briefings and meetings, with both myself and with Ministers, in order to coordinate different phases of the vaccination programme, from establishment, to update, to booster rollouts.

116. Andrew's advice was fed in through our structures, and the groups he was involved with, most notably in respect of his role securing an effective vaccination programme. He would have been entitled to issue professional advice directly to pharmacists in Wales, and he maintained close contact with the network of pharmacy leads across Wales, and liaison with his colleagues across the UK.

Other key individuals

117. In addition to those individuals mentioned above, I also worked closely with, and relied upon professional advice and support from: -

117.1. Fliss Bennee, co-Chair of the Technical Advisory Cell and the Technical Advisory Group (with Rob Orford, Chief Scientific Adviser for Health). As I explain at paragraph 100, the work that Fliss and Rob undertook leading the provision of technical and expert advice to the Welsh Ministers was vital in

ensuring that the right decisions were taken at the right time to protect the people of Wales.

117.2. Jo-Anne Daniels, Director of Mental Health, Vulnerable Groups and NHS Governance, and lead Director for Test, trace, protect from April/May 2020 onwards. The role that Jo-Anne played in delivering Test, Trace, Protect in Wales, working collaboratively with our partners nationally and locally is described in more detail in paragraphs 323 to 331 of this statement, and I am grateful to her for the work that she did in this role.

117.3. Clare Rowlands, Interim Director of Vaccines. While I understand that the Inquiry's examination of the Welsh vaccination programme will be examined in a later module, I would like to acknowledge the important role that Clare played in ensuring that the vaccination programme was delivered successfully, and at pace.

117.4. Joanna Jordan, Head of the Health and Social Services Group.

117.5. Alan Brace, Finance Director and Chair of the PPE Supplies Cell of the HSS Planning and Response Group.

117.6. Steve Elliot, Director of Finance, Health and Social Services Group.

117.7. Gill Richardson, initially as Senior Professional Advisor to the Chief Medical Officer and later as Vaccine Programme Director and additional Deputy Chief Medical Officer.

117.8. David Goulding, Health Emergency Planning Advisor.

118. This list is not exhaustive, and it will not be possible to acknowledge the contribution of every Health and Social Services Group official who supported me though the pandemic in this statement. However, I would like to take this opportunity to record my pride in, and gratitude to, all those officers working across the Health and Social Services Group who went above and beyond on many occasions to provide the highest quality advice to me and to ministers, to protect the people of Wales. This support was provided professionally, with urgency, and beyond normal expectations knowing that

we were responding to an unprecedented challenge of scale and impact. Despite all these pressures, I am grateful for the collaborative approach teams and individuals took and the way in which they reached out to external organisations and agencies to improve our advice and actions.

119. I should also explain that close collaboration and cooperation, both within the Welsh Government and across the wider public sector and health and social care system in Wales, were instrumental in informing, planning, and implementing HSSG's response to the pandemic. While much of this collaboration took place through formal structures and channels, informal collaboration founded on strong working relationships between individuals who had worked together, often over many years, within the relatively intimate health and social care system and within an embedded culture of partnership working in Wales, was also integral to the work of HSSG during the pandemic. I would also like to take this opportunity to thank everyone across the whole health and social care system, and Welsh public services more broadly, who worked tirelessly to protect and promote the health and wellbeing of the populations they served.

The First Minister and the Welsh Ministers

The First Minister and Cabinet

120. The First Minister's role and the role of the Cabinet are explained in my statement ref. **M2B/WG/01**.[3]

121. While the Permanent Secretary, Dame Shan Morgan, was the principal adviser to the First Minister and to the Cabinet, my role as Director General, HSS and NHS Wales Chief Executive developed during the early phase of the pandemic. I met with the First Minister regularly, both formally and informally, and by invitation attended Cabinet meetings alongside, and in support of, the Permanent Secretary, given the health focus of the Welsh Government's pandemic preparation and response, and my management responsibility for NHS Wales.

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[3] See paragraphs 27 to 38, 66 to 69, 143 to 146, and 247 to 250 of that statement.

122. Prior to the pandemic, Cabinet would meet weekly while the Senedd was in session. I would attend Cabinet rarely, and only when Health and Social Services Group papers on significant health and/or social care policies were to be decided, adopting a support role to Ministers.

123. In the early months of the pandemic, Cabinet meetings ran on a hybrid basis, with a small number of people including the First Minister, the Minister for Health and Social Services and myself gathering in person in a meeting room in Cathays (the Welsh Government's principal office in Cardiff), with a larger number of people joining the meeting virtually. This enhanced format allowed greater and wider participation; Deputy Ministers attended these meetings, and all senior officials with a role in the pandemic response were able to observe.

124. In March 2020, the First Minister established a Core Ministerial Group (also referred to as the Core Covid Group) that would meet weekly every Wednesday morning. The purpose of these meetings was to allow senior officials to brief Ministers with direct responsibility for the pandemic response on the emerging situation but, as I recall, with a broader invitation to all Ministers to attend. I would attend these meetings, together with the Chief Medical Officer for Wales, Frank Atherton, the co-Chair of TAC, Rob Orford, and the Director of Local Government and Civil Contingencies, Reg Kilpatrick. The Director of Social Services and Integration and my Deputy Director General, Albert Heaney, attended when needed to provide a social care commentary, either through me or directly to Ministers himself. Membership of this Group gradually expanded to include key partners and stakeholders, such as the military, police, the Welsh Local Government Association, the First Minister's Black, Asian and Minority Ethnic Advisory Group, and the Wales Council for Voluntary Action. I would brief this group on the current state of NHS preparedness, capacity, and resilience, to assist understanding and consideration, ahead of final decision-making processes. This was provided alongside reports by others, notably Frank Atherton's public health briefings, Reg Kilpatric's reports on contingency planning and other public services, and Rob Orford's advice and interpretation of the latest scientific evidence and data.

125. By early July 2020, the Cabinet had settled into a regular routine of Monday morning meetings, with an expanded membership. I routinely attended Cabinet meetings by invitation as an official, to brief Ministers and Deputy Ministers on key health and social care indicators, most notably once the 21 day review cycle was established and I was

required to personally attend and to provide advice to Ministers on the capacity and resilience in the health system, to inform their assessment of whether to impose or lift certain NPIs as part of the 21-day review process (see paragraphs 147 to 153 of this statement for a more detailed explanation of my involvement in the 21-day review process).[4] Occasionally, I would be asked to provide updates to the Cabinet on other areas within my Director General portfolio.

126. I reported to the First Minister and to Ministers on a daily basis through my daily reporting, and the First Minister would occasionally contact me, either directly, or by email or via his office, to clarify matters in those reports. I would also join, by invitation, the First Minister and the Minister for Health and Social Services at meetings with stakeholders (discussed further below).

127. By way of example, I produce here a small sample of these daily updates which reflect their changing tone as pressure on the health system waxed and waned in response to increasing Covid-19 transmission and infection rates: -

127.1. **Exhibit M2B.WG.AG.01/011 – INQ000350326**: 4 June 2020;

127.2. **Exhibit M2B.WG.AG.01/012 – INQ000350099**: 15 December 2020;

127.3. **Exhibit M2B.WG.AG.01/013 – INQ000350190**: 24 January 2021;

127.4. **Exhibit M2B.WG.AG.01/014 – INQ000350307**: 22 March 2021;

127.5. **Exhibit M2B.WG.AG.01/015 – INQ000350325**: 21 May 2021; and

127.6. **Exhibit M2B.WG.AG.01/016 – INQ000350404**: 9 August 2021.

128. While decision-making was directed through Ministerial Advice, Cabinet discussions, and through the 21 day review process, the First Minister was always keen to have a sense of the NHS' status and concerns, and my briefings to him (both via my daily

[4] I understand that Cabinet papers have been disclosed to the Inquiry as part of the general disclosure provided by the Welsh Government.

reporting, and through the weekly Core Covid Group briefings) fed formally and informally into those decision making processes. He and I had shared experiences in overseeing the NHS in Wales when he was the Minister for Health and Social Services, and I was Director General / NHS Wales Chief Executive, and this established his trust and confidence in my personal assessment and judgement.

129. I would participate, where requested, in discussions on a broader range of topics than the health service, but not in all. The First Minister was entitled to ask for my advice on any relevant issues when he wanted or required it, and I would respond.

The Welsh Ministers

130. As Director General, HSS and NHS Wales Chief Executive I was the principal policy adviser to the Minister for Health and Social Services and the Deputy Minister for Health and Social Services.

131. The Minister for Health and Social Services is responsible for NHS Wales, policy in relation to (but not the delivery of) social services and social care, public health and health protection, the Food Standards Agency, post-graduate medical education, and NHS charging in Wales. Between 2016 and 12 May 2021, the Minister for Health and Social Services was Vaughan Gething MS. On 13 May 2021, he was succeeded by Eluned Morgan MS, Baroness Morgan of Ely.

132. Julie Morgan MS was the Deputy Minister for Health and Social Services between 13 December 2018 and 12 May 2021. She was appointed Deputy Minister for Social Services on 13 May 2021, following the May 2021 Senedd elections.

133. As part of my role, I would make assessments to support ministers in their decision making. These assessments would reflect the factual position in respect of NHS capacity, using the available data, but I also sought to capture and convey the tone of NHS Wales. This was important to me, and I endeavoured to ensure that the voice of the healthcare system was captured through my regular discussions with leaders across the healthcare system, and conveyed to ministers. I also used these assessments, in consultation with Albert Heaney, to update Ministers on capacity and resilience in the care system, and to alert Ministers to emerging issues in social care.

134. I believe there was trust and confidence in my advice and assessments, and I responded to any questions or concerns from Ministers arising from those assessments and advice. There were formal and informal contacts points, from regular Ministerial meetings to 1-to-1s. Not all meetings were pandemic related, as there were other priority areas and actions for government; nevertheless, they took place in a covid context as this was the clear priority for the Welsh Government and for Ministers. I also continued to attend the routine Covid-19 briefings, that particularly supported the Minister for Health and Social Services and the First Minister to discharge their functions in respect to the pandemic.

135. I would attend, when needed, Inter-ministerial Group meetings across the UK, and accompany Ministers in direct discussions with individual health organisations, including Public Health Wales. I also supported Ministers in external and stakeholder meetings, including with NHS bodies and other agencies. This didn't mean I attended every meeting, as other officials both senior, such as the Chief Medical Officer, and junior would attend meetings with the Minister to provide support depending on the topics under discussion and their particular expertise. This was consistent with the way in which I led my immediate team, and the wider Health and Social Services Group, through the pandemic. I trusted and had confidence in my team's ability to provide appropriate advice and support to the Minister, and to lead within their own areas of responsibility. While I was always available for advice and support, when called upon, I established structures early on that allowed me to effectively delegate day to day responsibility for many issues and actions, while retaining oversight and overall accountability, and then I trusted my team to deliver on those issues and actions. Not only was this necessary, because I simply couldn't have retained day to day management responsibility for all the Group's functions, but it meant that Ministers received the right advice, when they needed it, from people with far greater expertise within their areas of specialism than me. For example, and as I discuss later on in this statement, the Deputy Chief Medical Officer and the Chief Nursing Officer, through leadership of the Nosocomial Transmission Group, were far better able to provide advice to Ministers on the measures necessary to minimise the risk of nosocomial infection and transmission, than I was and while I was sighted on their advice, I would defer to their expertise in that area.

136. I would also pick up issues, when needed, with special advisers to the First Minister and to the Minister for Health and Social Services, noting their role as a bridge between

officials and ministers and to help officials to deliver against ministerial priorities and objectives. Chief among these was Clare Jenkins, although I also liaised frequently with Jane Runeckles. I have always found the relationship between special advisers and officials to be a normal part of the day to day workings of government, an opportunity to share information or concerns, and to clarify expectations and ambitions of ministers. They form part of the daily workings of government and support the business of government. However, while they were invariably helpful, decisions were always routed through the formal decision making structures, principal among which were the Cabinet process (discussed above) and the Ministerial Advice process (discussed immediately below).

Ministerial advice

137. A ministerial advice ("Ministerial Advice") is a document that is prepared by civil servants and submitted to the relevant minister(s) for the purpose of providing them with the information, options, and advice they need to enable them to decide. Ministerial Advice is drafted by civil servants of appropriate seniority, with knowledge of the legislative, financial, or policy issue(s) under consideration. Once drafted, a Ministerial Advice goes through a clearing process before being submitted. A senior civil servant, typically a director or director general, must assure that the advice contained in the Ministerial Advice has a sound evidential basis and accurately presents the available information and options, that the recommended decision or action would be lawful, affordable, and would comply with all relevant statutory requirements, and that cross-portfolio implications and the Welsh Government's wider policy objectives have been considered. Where appropriate, the Ministerial Advice is also assured by governance, finance, and legal colleagues. Once cleared, Ministerial Advice is submitted to the relevant minister(s) for decision, and copied to other ministers, officers, and special advisers ("Spads") with a particular interest in its subject matter.

138. Ministerial Advice is usually prepared by the senior official with the greatest knowledge and understanding of the issues raised in the advice. I trusted advice coming up through the Health and Social Services Group and while I assured many of the Ministerial Advice documents that went to Ministers, and had sight of many more, it was only on rare occasions that I played a more active role in shaping the advice and recommendations. However, there were key moments when I stepped more directly

into the preparation of the documents and the recommendations to Ministers, as they addressed issues requiring my more personal interest and experience.

139. For example, the system risks paper dated 16 November 2020 that updated Cabinet on capacity in the health system following the fire-break lockdown required my input because I needed to ensure that the pressure on the health system was recognised and understood, and that the Cabinet's decision whether to ease restrictions following the fire-break lockdown was informed by clear advice. I produce here, as exhibit **M2B.WG.AG.01/017 – INQ000048933**, the system risks paper that was presented to Cabinet on 16 November 2020, together with the Cabinet paper to which it was annexed as exhibit **M2B.WG.AG.01/018 – INQ000048996**.

140. On 25 November 2020, I attended a Ministerial call to update Ministers on the NHS position ahead of a planned Cabinet meeting the following day. I explained, by reference to three potential trajectories for NHS capacity and resilience (produced here as exhibit **M2B.WG.AG.01/019 – INQ000350029**), the impact of rising infections on the NHS and the concerns being raised by the system about its ability to meet such high levels of demand. The minutes of that meeting, which I produce here as exhibit **M2B.WG.AG.01/020 – INQ000350028**, record that: -

"By January, with the impact of Christmas mixing, we could see community prevalence at over 500 per 100k, and numbers of covid-related cases in hospital at over 1500 confirmed covid patients, and over 2500 total covid-related patients by 12th January, and continuing to increase through January. These would represent the highest reported positions seen at this critical point.

By adjusting activity, bringing field hospitals back on stream, and other measures, the NHS would not be overwhelmed in capacity terms at this level, but the circumstances would represent an extreme level of pressure, alongside winter pressures, with consequences: the stress on staff would be of serious concern and some difficult choices would be required to reduce other NHS activities. With these numbers of people seriously ill from covid, the number of deaths would increase, with potentially 1600 additional avoidable deaths if no further interventions were agreed (a total of 3624 deaths), compared to options that could limit this to a lower level of 2000 deaths through this period with interventions".

141. I also produce here the minutes of the Cabinet meeting held the following day, 26 November 2020, as exhibit **M2B.WG.AG.01/021 – INQ000048925**.

142. I continued to provide regular updates to the First Minister and to the Minister for Health and Social Services which articulated the concerns of the health system about capacity and resilience in the NHS. I produce, by way of example, my email updates to the First Minister and Minister for Health and Social Services on 8 and 9 December 2020 as exhibit **M2B.WG.AG.01/022 – INQ000350062**, and my paper to the Cabinet on 10 December 2020 as exhibit **M2B.WG.AG.01/023 – INQ000048916**. At that meeting on 10 December 2020, Cabinet agreed a framework of actions to mitigate the risk of potential harm to patients who required access to essential healthcare services (exhibit **M2B.WG.AG.01/024 - INQ000022517** refers), and I communicated these to the chief executives of local health boards and NHS trusts by letter the same day (exhibited as exhibits **M2B.WG.AG.01/025 – INQ000350069** and **M2B.WG.AG.01/026 – INQ000350070** respectively, are my letter to NHS chief executives and its accompanying annex).

143. The advice that I provided to Ministers during this period reflected the acute pressures that were being experienced in the health system, and the messages I was receiving from leaders in the system about the seriousness of the situation. In my recollection, this period was the most difficult and the most challenging for the NHS in Wales. Whereas in earlier phases of the pandemic response we had, quite properly and by necessity, paused some of the routine NHS workload and refocussed priorities to the immediate task of responding to the pandemic, by winter 2020 we were looking to restore services, building on the core and essential services that had been retained throughout the pandemic. However, we were also seeing the growing impact of Covid-19 patients admitted to hospital on our NHS bed capacity and we were heading into our first winter with an ongoing Covid-19 response. While there was capacity available, there was significant concern about the NHS' resilience. We therefore had to plan for the normal winter pressures that arise every year, alongside a high number of Covid-19 patients in hospital beds, knowing the impact on patients and staff (and staff absence) of high numbers of hospital admissions, as community transmission and infection levels were increasing. There was acute concern throughout the system about the risk of harm to patients during this period.

144. This period was an extraordinarily difficult time with real commitment across the Health and Social Services Group and by staff working in the NHS and care to focus on patients and those needing care. My firm view is that if ministers had not acted to put in place restrictions at this time, the NHS's capacity and resilience would have continued to deteriorate and I believe there would have been more cases, more admissions and sadly more deaths. Given our underlying objective to ensure the NHS was not overwhelmed, and the impact of that, this period in my professional view came 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, when beds are occupied by Covid-19 patients, the NHS is unable to discharge fully its broader responsibilities and activities, which in turn impacts on the long term ability of the NHS to deliver other health services.

145. Similarly, in January 2021, I took a more active role in preparing a briefing paper for the First Minister and Ministers on the vaccination infrastructure and roll-out, as it was important that Ministers were aware of the structures and processes we were putting in place for vaccinations moving forward and I needed to provide more direct support to officials to ensure that the advice we provided met Ministers' expectations pending a dedicated director appointment. I produce here, as exhibit **M2B.WG.AG.01/027 – INQ000350143**, a copy of this briefing paper dated 2 January 2021.

146. On most occasions, however, I involved myself in the drafting only at key points when I spotted concerns, or a need for clarity for Ministers.[5]

147. In respect of NHS capacity issues, members of my team, such as Andrew Sallows, provided supporting assessments and advice around technical papers, but given that I was giving personal updates to Cabinet at routine and critical points, I needed to own the advice being provided. The daily assessments, that I reference at paragraph 125 above, I chose to prepare personally, as these daily reports gave a narrative on pressures and issues, supported by data, and allowed an informal sense of the day to

[5] I understand that the Ministerial Advice provided by me, assured by me, or provided or assured by other officials in the Health and Social Services Group have already been disclosed to the Inquiry as part of the Welsh Government's general disclosure.

day changes in the system. While there were other more formal sources of data tracking progress, I found that these daily reports allowed a tone and assessment from me that the FM, Ministers and others could track alongside me.

The 21 day review process

148. Management of the 21 day review process sat with the Covid-19 Project Team, led by Reg Kilpatrick. TAC would provide an assessment, based on the latest data and modelling for Wales, and members of the HSSG, particularly the CMO(W) and CSA(W), would provide advice on the options available, and the potential implications of each option.

149. While I had oversight of the work of the officials within my Group, and the various groups and bodies within HSSG that contributed data and evidence to that assessment, my primary role in each 21 day review was to provide an assessment of NHS capacity, and resilience, and an accompanying commentary. That commentary outlined the existing pressures in the system, the actions that HSSG was taking to assess capacity, build resilience and implement mitigating actions where needed to support the sector, and the capacity of the NHS to address the likely impact of recommendations to impose, or lift, certain NPIs.

150. On occasion, I shaped the submission more personally, in respect of the key issues for the NHS and its resilience. At the 21 day review meeting on 1 October 2020, the data showed that case numbers were rising significantly. Data from the Test, Trace, Protect programme showed that each case was resulting in four to five contacts, which was a strong indicator that people were beginning to socially mix more. There was real concern that rising infection rates in the over 60 population was leading to acute pressure in NHS intensive care wards. The decision was taken not to lift the nationally imposed restrictions. I produce here, the Cabinet paper on the 21 day review as exhibit **M2B.WG.AG.01/028 – INQ000048989**, together with the summary of restrictions (as exhibit **M2B.WG.AG.01/029 – INQ000048998**) and the key indicators table (as exhibit **M2B.WG.AG.01/030 – INQ000048995**) that accompanied it. I also produce the minutes of the Cabinet meeting as exhibit **M2B.WG.AG.01/031 – INQ000022497**.

151. On Thursday 15 October 2020, the First Minister called an emergency Cabinet meeting to seek the agreement of the Cabinet to a fire-break lockdown. Cabinet agreed in

principle, and that a substantive decision should be made at the next Cabinet meeting on Monday morning, to allow Ministers the opportunity to consider the recommendations carefully before taking a final decision. Cabinet met again on Sunday 18 October 2020, before making a final decision to impose a fire-break lockdown on Monday 19 October 2020.

152. I produce here the following exhibits, which show the advice submitted to, and decisions taken by, the Cabinet in the run up to the firebreak lockdown: -

152.1. the minutes of the Cabinet meeting held on 15 October 2020 **as exhibit M2B.WG.AG.01/032 - INQ000048796**;

152.2. the Cabinet paper on the firebreak lockdown, as exhibit **M2B.WG.AG.01/033 – INQ000048887**, together with its annexes: -

152.2.1. the Technical Advisory Cell's paper to Cabinet, as exhibit **M2B.WG.AG.01/034 – INQ000227462**;

152.2.2. proposals for the shape of the firebreak, as exhibit **M2B.WG.AG.01/035 – INQ000048878**;

152.2.3. issues to be resolved in respect of the firebreak, as exhibit **M2B.WG.AG.01/036 – INQ000048879**;

152.2.4. options for restrictions post-firebreak, as exhibit **M2B.WG.AG.01/037 – INQ000048880**;

152.2.5. options for utilisation of the firebreak period, as exhibit **M2B.WG.AG.01/038 – INQ000048881**;

152.2.6. children's rights and the firebreak options, as exhibit **M2B.WG.AG.01/039 – INQ000048882**; and

152.2.7. the equality impact assessment, as exhibit **M2B.WG.AG.01/040 – INQ000281897**;

152.3. the minutes of the Cabinet meeting held on 18 October 2020, as exhibit **M2B.WG.AG.01/041 – INQ000048801**;

152.4. the Covid-19 data monitor dated 19 October 2020, as exhibit **M2B.WG.AG.01/042 – INQ000350508**; and

152.5. the minutes of the Cabinet meeting held on 19 October 2020, as exhibit **M2B.WG.AG.01/043 – INQ000048802**.

153. Most of the other assessments adopted a more routine and consistent format, but the concerns and exceptional circumstances at that time required a very clear, honest and robust assessment of the NHS outlook.

154. However, it's important to emphasise that mine was a factual voice at Cabinet, not a policy one. I would provide Ministers with an explanation of the strengths and risks in the system, and its capacity to respond to different policy options, but I would not advocate one particular course of action, or another. My role was to help Ministers to contextualise the different policy options, so that they can take an informed decision on the best approach, depending on the circumstances and with regard to the wider sector issues beyond the health and care systems. It was for Ministers, ultimately, to balance competing harms[6] and decide on what course of action to take.

Key committees, bodies and forums

155. Before I turn to explaining my role in the various decision making bodies and committees within the Welsh Government, I would like to make a few general points about how decisions are taken within the Welsh Government, and with our partners and stakeholders across Wales.

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[6] At paragraphs 278 to 279 of my statement ref. **M2B/WG/01 –** I explain how the Welsh Ministers evaluated whether to impose, or lift, NPIs against five harms: i) direct harm to individuals from SARS-CoV2 infection and complications, ii) indirect harm caused to individuals if services, including the NHS, became overwhelmed, iii) harms from non-Covid-19 illness, iv) socioeconomic and other societal harms, and v) harms arising from the exacerbation of existing, or introduction of new, inequalities. While NHS capacity and resilience was most directly relevant to the first, second, and third harms, Ministers were always cognisant of the need to balance all five harms, and I was always cognisant that my assessment would be understood and interpreted in that wider context.

156. Across the Welsh Government, the First Minister and the Welsh Ministers strongly encourage officials to engage collaboratively with partners across a range of different sectors, and with expertise and specific interests in the whole range of devolved functions and responsibilities. In my experience, ministers expect the advice they receive to be informed by, and wherever possible prepared in consultation with, our partners and stakeholders. Consequently, while robust governance structures and processes are required to effectively protect and deploy the Welsh Ministers' statutory decision-making responsibilities and powers, there is an expectation that officials will actively engage with those outside the Welsh Government to inform decisions.

157. This approach is perhaps best illustrated by the many partnership groups and forums that are in place in Wales (see paragraphs 207 to 277 of this statement), which were instrumental in informing our pandemic preparation and response in Wales. This practice was recently put on a statutory footing through the enactment of the Social Partnership and Public Procurement (Wales) Act 2023.

158. Due to the Health and Social Services Group's compact size, we needed to make best use of the available expertise and capacity across the wider health and care systems, and this enabled us to deliver effective pandemic preparations and response at pace. Within my portfolio of health and social services, I and others in the Health and Social Services Group very explicitly and visibly reached out to NHS organisations and representatives, care commissioners and providers, and other stakeholders to bring them even further into our decision making processes during the pandemic. This was done with the express approval and support of the Minister for Health and Social Services. In the care sector, where the Welsh Government's powers are more limited and, consequently, its ability to intervene directly in the system is restricted, our outward looking and collaborative approach enabled the Welsh Government, primarily through Albert Heaney, to exercise enhanced leadership and oversight over the system at a time when it was looking to the Welsh Government for support.

159. This engagement had many benefits. Bringing our delivery partners, stakeholders, and leaders from the health and care sectors into our early thinking both improved the quality of our advice to ministers, which in turn supported better decision making, and built trust across the system. Included in this was also a number of clinical and professional groups, bodies, and committees as summarised in paragraph 276 below. This will be explored further in module 3 of the Inquiry but it was personally very

important to me that we not only ensured our advice to ministers and decisions were informed by the system leaders but also by those on the frontline. This improved understanding within the system in those moments where the system might have preferred a different, or more urgent, response to the issues they were facing, as we were able to contextualise the action being taken by reference to broader risks, potential harms, considerations. By consulting our partners on our emerging thinking at an early stage, we were able to avoid shocks to the system and support their preparation, facilitating much more rapid implementation of decisions once they had been taken than would otherwise have been possible.

160. While this was a common practice across the Welsh Government, as I have explained, I made a personal choice to make determined effort to consult, update, discuss with, and listen to the NHS in Wales and bring them closer into our decision making, as I explain further below.

Welsh Government Board

161. The Welsh Government Board oversees the governance and organisational strategy for the Welsh Government. It sits alongside the Executive Committee (described at paragraphs 162 to 166 of this statement) and provides strategic advice, challenge and assurance for the organisation. The role of the Board is to provide: -

161.1. Assurance to the Permanent Secretary in discharging their role as Principal Accounting Officer. The Board supports them to ensure that the organisation operates to the highest standards of governance, financial management, management of risks and processing of the annual accounts.

161.2. Strategic advice on the delivery of the Government's priorities in line with the Programme for Government.

161.3. Challenge to the organisation and advice to the Permanent Secretary on organisational strategy, design and workforce planning to ensure the organisation continues to be fit for purpose, adequately resourced and promotes equality and diversity throughout the organisation.

162. In addition to the Permanent Secretary and directors general, the Board membership includes a number of directors (including those responsible for governance and ethics, the treasury, legal services, and organisational design and engagement), and four non-executive directors.

163. As Director General, HSS I was a core member of the Board. I provided updates on, and highlighted relevant issues arising within, my portfolio when needed, but my primary role was to participate in the Board's corporate governance and assurance functions and, through that participation, to provide support and assurance to the Permanent Secretary.

Executive Committee

164. The Executive Committee ("ExCo") is the operational and strategic decision-making forum that supports the day to day running of the Welsh Government. ExCo is the primary decision-making forum through which key decisions are taken in respect of delivery of the Welsh Government's agenda, leading and developing the Welsh Government Civil Service, and effectively managing public money.

165. ExCo's membership comprises the Permanent Secretary, the directors general, and the senior staff who lead the Welsh Government's corporate functions.

166. As Director General, HSS I was required to update ExCo on significant matters and issues in my policy area and contribute, from both my group and personal perspectives to the broader objectives of Exco and the organisation. Under the former Permanent Secretary, Dame Shan Morgan, while there were opportunities to raise issues of concern from within the Health and Services Group the focus was directed at a corporate level rather than on group issues and this meant that many issues, with an assumption of confidence, were delegated to directors general to lead and manage.

167. Through ExCo, I participated in collective decision making on matters relating to considerable change to the whole or the majority of the Welsh Government, programmes of work with significant costs, major issues or those issues that could not be resolved at Group or sub-committee level, and matters that would impact the reputation of the Welsh Government. I also acted as a conduit through which ExCo's

decisions and key messages were communicated to senior leaders in the Health and Social Services Group, and across the wider Group.

168. While ExCo's agenda and decisions were inevitably shaped by the Covid-19 context, the establishment of ExCovid (see paragraphs 167 to 171 immediately below) as a dedicated Executive-level decision making forum for pandemic preparation and response, did generally protect ExCo and enable it to continue to drive and support the other organisational objectives and issues that needed to be managed throughout the pandemic.

ExCovid

169. On 18 February 2020, the then Permanent Secretary, Dame Shan Morgan, established an expanded ExCo, named ExCovid, to oversee and co-ordinate the actions of the Welsh Government Civil Service in responding to the Covid-19 pandemic.

170. The purpose of ExCovid was to bring together directors general, directors, and other key officials from across the Welsh Government, to provide regular, senior level oversight and monitoring of the Welsh Government's response to the Covid-19 pandemic. ExCovid was primarily an information sharing forum which provided high level assurance that the Welsh Government had an effective and joined-up response to the crisis in place.

171. I understand that the decision to establish ExCovid, its role and functions, are described by Dame Shan Morgan at paragraphs 37 to 43 of her statement to the Inquiry ref. **M2B/WG/SM/01**.

172. While I attended ExCovid alongside the other directors general, I had a more distinctive role to update colleagues on the status and outlook of the pandemic, supported by the Chief Medical Officer for Wales and the Chief Scientific Adviser for Health, and to highlight relevant issues to the committee. I also responded to any issues arising in respect of the NHS in my capacity as NHS Wales Chief Executive, and across the wider health and social services portfolio, as Director General, HSS. I also updated my senior colleagues on the progress with key actions to mitigate the risks posed to the population, such as Test, Trace, Protect and the vaccination programme, as it was

important that senior colleagues across the organisation received regular updates on the efficacy of these measures, to inform the pandemic response in their areas of responsibility.

173. In my opinion, ExCovid provided an important opportunity to review and assure the pandemic response across the organisation at regular intervals, outside the formal decision making structures of ExCo.

My Executive Directors Team

174. Prior to the commencement of the pandemic, I held weekly meetings of the directors in the Health and Social Services Group to bring together information, identify leadership actions and to make decisions across the Group's functions and responsibilities. These 'EDT' meetings, held weekly, provided an important routine and beat that supported knowledge sharing, understanding and decision making.

175. These EDT meetings were an important part of my oversight of the work of the Health and Social Services Group, facilitating collective oversight of issues across the Group and decision making and direction on urgent or emerging issues. EDT agendas covered the full range of the Group's responsibilities, from NHS performance and resilience, through to policy development including in respect of social services, and internal group prioritisation and resourcing decisions. My practice was to personally clear the agenda, although there was always an opportunity for directors to raise urgent issues. I would also use the EDT meetings and agenda to draw in relevant system or internal group issues and areas of concern, for direction or decision-making. I would chair the meetings, or in my absence either the Deputy Chief Executive NHS Wales or another director would chair.

176. I specifically maintained these EDT meetings throughout my tenure as Director General, HSS and NHS Wales Chief Executive and during the pandemic as a way of bringing together the various workstreams, activities and actions happening across the Group in response to the pandemic. These EDT meetings also allowed me to step in and provide direction or take decisions, where needed, to drive our response.

177. I also established an EDT Contingency Group at the start of the pandemic to provide more focussed oversight of the risks and issues arising within the Group. Paramount

among these was of course the Covid-19 pandemic, but the EDT Contingency Group also considered risks emerging from the UK's departure from the European Union and planning for winter pressures in the health and care systems.

178. EDT Contingency Group meetings, which were held weekly, provided an important opportunity to address any pressing matters in the Covid context, and an internal sounding board that informed and enhanced the advice provided to ministers. As the Chief Medical Officer, Chief Scientific Adviser for Health, Chief Nursing Officer, Deputy NHS Wales Chief Executive as well as the programme leads for key projects like Test, Trace, Protect and the vaccination programme were all members of the EDT Contingency Group, these meetings were an important opportunity for challenge, and for subject matter experts and technical specialists to help shape advice, options and recommendations before they were presented to ministers.

179. They also protected the time we needed at the routine EDT meetings to address the wider work of the Health and Social Services Group, which while informed and influenced by the Covid context, still needed to be progressed.

180. The balance between Covid-19 and non-Covid-19 related work of the Group inevitably changed over time as the as the routine and experience of the pandemic response changed through the different phases of the pandemic, and this was reflected in the roles that the EDT and EDT Contingency Group played in my oversight of the Group.

181. While the EDT and EDT Contingency Group meetings provided an important beat throughout the pandemic, I would meet regularly with my directors on a one-to-one basis, both as a matter of routine and to discuss specific and urgent issues.

Health and Social Services Covid-19 Planning and Response Group

182. In February 2020, I established the Health and Social Services Covid-19 Planning and Response Group ("HSS Planning and Response Group") for the purpose of bringing together representatives from the Health and Social Services Group, NHS Wales, and the social care sector to provide a strategic interface for health and social services in Wales. This helped to support a health-led response to the initial phase of the pandemic and was consistent with the requirement to establish appropriate health system infrastructure in line with the Pan Wales Response Plan. The HSS Planning

and Response Group also provided a basis for ongoing collaboration, and co-design with the wider health and social care systems, and access to health and care expertise outside the Welsh Government.

183. I explain my decision to establish the HSS Planning and Response Group, its constitution, role and responsibilities in detail in my statement ref. **M2B/HSSG/01** (see, in particular, paragraphs 98 to 104 of that statement), and I do not repeat that evidence here except to explain my purpose and intention in establishing these arrangements, and how they supported me to discharge my professional responsibilities during the pandemic.

184. The HSS Planning and Response Group reflected my leadership of, and oversight over, the health and social care systems and the Welsh Government's health and social services response to the pandemic. It reported to me, providing me with assurance on reasonable worst case scenario planning, preparedness, emerging risks and issues, and the coordination of our preparation and response across the Health and Social Services Group. However, the governance structures around the HSS Planning and Response Group also recognised and reflected the elevated role that Frank Atherton, as the Chief Medical Officer for Wales, was playing as the critical public health adviser for Wales and to us in the Welsh Government.

185. The HSS Planning and Response Group was a critical part of achieving my specific objective to bring our partners in health and care into the heart of Welsh Government decision-making during the pandemic. The Group ensured that decisions were taken collaboratively whenever possible, and following meaningful consultation, even when decisions needed to be taken at pace in response to rapidly changing circumstances and changes in our understanding of the risks posed by Covid-19. This objective was notably supported by the Group's co-chairing arrangements and those of its sub-groups (see paragraph 185 below).

186. By choice, we welcomed views from the system, both routinely and at key moments, to ensure that the direction of travel on the imposition and lifting of non-pharmaceutical interventions and on other system actions was supported by the NHS and stakeholders. It was important to ensure that the NHS voice was available to ministers, through my NHS Wales leadership role and through the direct participation of the system in the consideration of different options and preparation of advice. My aim was

that my advice to ministers was always in line with the changing tone and experience of the system, and informed by the NHS assessment externally to the Welsh Government. The HSS Planning and Response Group ensured that the systems' views on critical issues were raised into other decision-making mechanisms, including policy development for health and social services, national NHS decision making, the preparation of Ministerial Advice, and Cabinet decision making when appropriate.

187. Leadership of the HSS Planning and Response Group and its sub-Groups (see paragraph 92 of my statement ref. **M2B/HSSG/01**) was deliberately balanced between Welsh Government officials and leaders from different parts of the health and care systems. This ensured a high level of collaboration and information exchange from the government to the system, and vice versa. This approach was highly effective and was maintained throughout the pandemic. It also helped to inform our structures and plans as we emerged from the pandemic.

188. In addition to formal reporting lines to myself and the Chief Medical Officer, the HSS Planning and Response Group also reported into an informal senior officers group comprising myself; Frank Atherton, Chief Medical Officer for Wales; Jean White, Chief Nursing Officer for Wales; Albert Heaney, Director of Social Services; Samia Edmonds, Chair of the HSS Planning and Response Group; Andrew Sallows, Delivery Programme Director for the NHS; and Gill Richardson, Senior Professional Advisor to the Chief Medical Officer (although there was an open invitation for other directors to attend if they wished and when they were available). This informal group acted as an information sharing forum, and a way of ensuring that the work of various groups, cells and bodies were coordinated effectively. It also provided a forum in which we could discuss the advice that we were providing to ministers, thereby ensuring a consistent and integrated approach across our respective responsibilities and portfolios.

189. The HSS Planning and Response Group met for the first time on 20 February 2020, eight days before the first confirmed Covid-19 case in Wales, and regularly (usually weekly) throughout the pandemic, although the frequency of meetings inevitably followed the changing intensity of the Welsh Government's pandemic response in response to the changing circumstances (as explained in the more detailed chronology in my corporate statement ref. **M2B/HSSG/01**).

190. The HSS Planning and Response Group also established a Health Desk in the Emergency Coordination Centre (Wales), which acted as a single point of contact for the HSSG, NHS Wales and partner agencies. Depending on the circumstances, the Health Desk role included providing initial health co-ordination, establishing 24/7 contacts with key health organisations, liaising with other UK Health Departments, and ensuring appropriate stockpiles and arrangements were employed to support NHS Wales. Albert Heaney established equivalent arrangements for the care sector, through the Social Care Coordination Hub.

Other committees, bodies and forums

191. I have been asked, through the Request, to explain my participation in a wide range of Welsh Government committees and bodies. As the Director General, HSS I retained overarching responsibility for all of the work of the Health and Social Services Group, including those committees and bodies that were established by officials working in the Group internally, with wider Welsh Government stakeholders, and with our partners and stakeholders outside government. However, while I would have retained oversight over each of these bodies, and participated when necessary at critical points in the pandemic response, it was not my practice to micro-manage my teams and officials, or to stand over them as they worked. I had complete trust and confidence in their ability to deliver against the objectives I had set, and to escalate matters to me when they my active support or intervention was required.

192. I address, briefly, some of those bodies below.

<u>TAG and TAC</u>

193. The establishment, constitution, role and work of the Technical Advisory Cell ("TAC") and the Technical Advisory Group ("TAG") are explained in the statement of the Chief Scientific Adviser for Health, Rob Orford ref. **M2B/TAG/01**.

194. The Technical Advisory Cell ("TAC") and the Technical Advisory Group ("TAG") were hosted out of the Health and Social Services Group, and consequently fell under my broader oversight as Director General, Health and Social Services. However, TAG and TAC were very capably led by Rob Orford (see paragraphs 93 to 101 of this statement)

and Fliss Benee, and I did not directly intervene in their arrangements, attend their meetings, or interfere with the advice they provided to ministers.

195. TAG played a critical role, providing evidence, advice, and reflections to ministers while remaining independent of, and without stepping into, ministerial decision making structures and processes. TAG's publications were highly regarded and incredibly important within the Welsh Government. TAG papers frequently accompanied key briefings and advices for ministers, and they were a lynchpin in the Cabinet-led 21 day review process.

196. While Rob and Fliss naturally worked very closely with the Chief Medical Officer for Wales, Frank Atherton, TAG and TAC's papers were produced independently from the Chief Medical Officer's papers to Cabinet and the other briefings and papers (including my own) that informed the Cabinet's decision making. This process ensured that ministers received objective evidence and impartial advice from a range of sources, thereby enabling them to balance risks and issues and to take the right decisions to keep the people of Wales safe from a range of different harms.

197. Rob and Fliss, in their capacity as the co-Chairs of TAC and TAG would present their papers at Cabinet and participate in ministerial discussions and calls, when required. Theirs were important voices around the table, but it was ultimately for ministers to decide.

198. I also personally welcomed the transparency and accountability that was an inevitable product of ministers' decision to publish TAG and TAC's research.

199. As well as receiving TAG and TAC's formal briefings and advices, I was also able to approach Rob and Fliss to access advice and to raise questions, when needed. However, I tended to rely on the expertise of Andrew Sallows, Delivery Programme Director for the NHS to reflect and filter much of TAG and TAC's advice for the NHS context, given his own leadership role and the support he provided to me as NHS Wales Chief Executive.

200. Perhaps inevitably, given that TAG and TAC's research was held in such high regard, the demands on their resources were significant and it became clear that some action needed to be taken to help them to manage the commissions and requests for advice

they received. Consequently, we later established the TAC Steering Group mechanism as a small but highly informed group that could help guide the best use of TAG and TAC's resources. This Steering Group comprised Rob and Fliss, me, Frank Atherton and Reg Kilpatrick, with Frank, Reg and I taking turns to chair meetings, to support diversity of thought and ensure no one individual dominated the Group's direction or priorities. While the Steering Group sought to recognise workloads, manage capacity and direct resources to priorities, we were always careful to maintain the group's independence and to protect the opportunity for members of TAG and TAC to 'follow their noses' and undertake work on their own initiative on emerging areas of particular interest or importance, and topics that arose from their own internal diverse consideration of the developing pandemic. The establishment of the steering group was purely supportive move, to try and filter commissions and expectations on the group who continued to act diligently and professionally at a time of great urgency and expectation.

201. The team did so much good and important work, translating evidence and data from UK and international sources for the Welsh context, and undertaking specific commissions to address issues that were particular to, or particularly important in, Wales. They were a fundamental part of the information, intelligence, and advice that fed into the top of government and up to the Cabinet. I firmly believe that the Welsh Government's response to the pandemic would have been less effective, and less successful, if we had not had the benefit of TAG and TAC's advice and support and had instead needed to rely on the UK-centric analyses provided through SAGE. In particular, it underpinned the context that ministers were using public health legislation to make decisions, in line with their devolved responsibilities, and needed advice to make the right and appropriate decisions for Wales.

Nosocomial Transmission Group

202. The Nosocomial Transmission Group was established for the purpose of providing advice, guidance and leadership for all health and care settings in Wales, including hospitals, primary and community care settings, registered care homes, domiciliary care, learning disability units, and prisons. Specifically, the Group was tasked with minimising nosocomial transmission (transmission within a healthcare setting), thereby enabling the safe resumption of essential services, by overseeing effective infection prevention and control measures in a variety of settings.

203. The Nosocomial Transmission Group was co-chaired by the Deputy Chief Medical Officer for Wales, Chris Jones and the Chief Nursing Officer for Wales, Jean White (and her successors Gareth Howells and Sue Tranka). Its membership comprised healthcare professionals and policy officers from within the Welsh Government, Public Health Wales, and representatives from a range of healthcare professions, their partners and trades unions. It's work is described in detail in the statements of the Deputy Chief Medical Officer (ref. **M2B/WG/CJ/01**) and the Chief Nursing Officers (Jean White, ref. **M2B/CNO/JW/01**, Gareth Howells, ref. **M2B/CNO/GH/01** , and Sue Tranka, ref. **M2B/CNO/ST/01**).

204. The Nosocomial Transmission Group required strong professional oversight and leadership and close collaboration with health and care professionals across the system, and this was capably provided by the Deputy Chief Medical Officer and the Chief Nursing Officer for Wales. Consequently, I did not directly involve myself in the Group's work.

205. The Deputy Chief Medical Officer and the Chief Nursing Officer for Wales undertook an important liaison role through a variety of professional networks and with their counterparts across the UK, ensuring that wherever possible there was consistent professional guidance for the NHS and social care providers across the UK. We were keen, wherever possible, to achieve consistency in professional guidance and advice to health professionals and I am grateful to Chris and Jean, Gareth and Sue for the work they did with their UK counterparts and with stakeholders both within Wales and across the UK to deliver credible and consistent advice for different settings in response to rapidly changing evidence on the spread and progression of the disease.

Senior Leaders Group

206. The Senior Leaders Group provides an opportunity for directors to engage with and obtain information and feedback on developing issues across the Welsh Government. The group meets every four to six weeks and is an informal forum to bring directors and directors general together with the Permanent Secretary.

207. As Director General, HSS I would attend meetings of the Senior Leaders Group to update colleagues on the status of work being undertaken in the Health and Social Services Group, and a broader outlook on pandemic preparation and response.

208. I personally felt that the Senior Leaders Group provided an important opportunity for directors, particularly, to become more familiar with the strategic work going on across Welsh Government outside their own groups and directorates, and to build understanding of and familiarity with concerns and outlook that may affect the work they were leading within their own portfolios. It was also one of the ways in which we sought to support and maintain open communication with all our staff throughout the pandemic, as we, as the senior leadership team, were acutely aware that our staff were also members of our communities and experiencing the pandemic in their own lives, families, and communities, as well as through their professional work for the Welsh Government. I also attended, at the Permanent Secretary's request, both senior civil service events (which were introduced by Shan as a mechanism for communicating with senior civil servants across the Welsh Government) and Shan's regular 'Let's Talk' events with all staff, to updates colleagues on the pandemic, and occasionally with other HSSG officials like Frank Atherton and Rob Orford, to speak about the pandemic response.

Partnership working

209. As I have explained throughout this statement, partnership working is very much an embedded way of working in Wales, and this guided my approach throughout the pandemic. I utilised our existing partnership arrangements, wherever possible, and supplemented these structures where necessary to meet the specific challenges presented by Covid-19. However, this partnership approach was reflected not just in our formal structures, but in the professional networks and relationships that I had developed over many years. Consequently, while I actively utilised our partnership structures, and sought to embed consideration of emerging issues in our existing infrastructure, I also relied upon my relationships to engage informally with partners at key moments, and when decisions needed to be taken at pace. Where urgent action was required for the NHS, it was not at all uncommon for me to sit in my office with a call list and systematically ring round key partners and stakeholders, to discuss my thinking and to test our emerging plans. These informal ring rounds frequently included the chief executives of local health boards and NHS trusts, key individuals in professional bodies, and our trade union colleagues, depending upon the particular action that I was considering taking. I would reflect that this was only possible because of the intimacy of the Welsh system, and the strength of the Welsh Government's relationships with stakeholders across that system.

210. In the section that follows, I highlight some of the key partnership structures that informed my actions and the advice I provided to ministers. It is not possible to reflect all the partnership working arrangements in place across the Health and Social Services Group in this statement, and I do not attempt to. Nor do I explain the many partnership bodies and arrangements that were led by other officials across the Health and Social Services Group.

NHS Wales Executive Board

211. The NHS system in Wales operates as a collaborative, planned system in which outcomes are optimised by chief executives, senior teams and organisations working together through a 'one Wales' approach. The NHS Wales Executive Board (which, from July 2021, was reset as the NHS Wales Leadership Board) provides the leadership forum to support this one Wales approach to the oversight and delivery of NHS functions in Wales.

212. The NHS Wales Executive Board provides executive leadership, direction, and oversight of the performance, delivery, quality, and safety of NHS services, workforce, and functions in Wales. It also provides a mechanism through which the Welsh Government can hold NHS chief executives collectively to account for the performance, operation, governance and functions of NHS bodies in Wales. It is important to note that direct accountability is through chief executives to me, through the accounting officer mechanism explained at paragraphs 23 and 24 above, but the NHS Wales Executive Board nevertheless provided an important leadership forum and was critical in maintaining a collaborative approach for Wales throughout the pandemic.

213. The NHS Wales Executive Board is attended by all directors from the Health and Social Services Group, the chief executives of the local health boards, NHS trusts, and special health authorities in Wales, and other senior leaders from across the health system such as the Director of the NHS Confederation in attendance and the Managing Director of NHS Wales Shared Services. I would set the agenda for the Board and chair meetings, to ensure that the discussions that took place were focussed on our key objectives and deliverables.

214. These board meetings provided an opportunity to both direct and guide the NHS in Wales and also receive feedback on emerging issues that may necessitate changes of policy or clearer guidance for the system. The board therefore acted as an important two way communication with leaders across the system, and an important forum for listening to the system's concerns and needs, so that we could act accordingly.

215. I have explained elsewhere in this statement that a particular and possibly defining feature of the Welsh healthcare sector is its intimacy and the close proximity between individual NHS bodies and, variously, national legislators and policy makers in the Welsh Government, other health bodies and organisations in the system, and the populations they serve. This proximity to government enabled rapid communication and discussion at critical points and ensured a constant two-way dialogue between the Welsh Government and NHS Wales. The NHS Wales Board played a vital role in this dialogue, and it was supported by other contact points with the system including national conference calls, planning and response sub-groups, and individual meetings with organisations.

Joint Emergency Services Group

216. The Joint Emergency Services Group was formed shortly after the introduction of the Civil Contingencies Act 2004. It brings the Welsh Government together with the emergency services and the armed services in Wales, at the most senior levels, and provides a forum where member organisations can discuss how to exercise their respective functions most effectively to ensure the protection of people in Wales. I have been a member of JESG in my role as NHS Wales Chief Executive since 2019, and I produce here, as exhibit **M2B.WG.AG.01/044 – INQ000107109**, the terms of reference of the Joint Emergency Services Group.

217. The NHS Wales Chief Executive role was not originally a formal member of the group, and NHS representation was provided by the Chief Executive of the Welsh Ambulance Service. However, it felt important from a leadership and system perspective to be personally in attendance, and to be part of emergency planning networks and activities alongside this group. This of course provided an established set of relationships and a networking mechanism that I used during the pandemic response to improve my understanding of the system's capacity and resilience. Those relationships meant that,

beyond the formality of the established structures, there was trust and confidence between the Welsh Government and emergency responders.

218. During the pandemic, meetings of the Joint Emergency Services Group provided an invaluable forum for sharing situational awareness and information about emerging risks and pressures between NHS Wales representatives, and emergency service organisations and agencies. SitReps and updates provided by each organisation provided valuable near real-time insight into pressures across the system, and the Welsh Government was able to brief those same organisations on the trajectory of the pandemic and its likely impacts, allowing for a much clearer understanding of key risks, their severity, and any mitigation required to offset or counterbalance those risks.

219. This approach also allowed me and Reg Kilpatrick to share emerging thinking, and to understand the potential impact of policy proposals on member organisations, and the system, before advice was finalised and decisions were taken. It also allowed participants to highlight system issues that required a national response or guidance directly to Reg and me, so the information exchange worked both from government to the system and from the system back to government.

220. The Joint Emergency Services Group met approximately every two-weeks during 2020, reflecting participants' commitment to it as an effective system contact, and at least monthly during 2021.

NHS Wales Chief Executives

221. As explained in paragraphs 13 to 18 above, the NHS in Wales is line managed by the Welsh Government through the Director General, HSS / NHS Wales Chief Executive role. There are regular contacts with the health system at the national, regional and local level. Formal national contact is through the NHS Wales Executive Board, and local contact and accountability is managed through my performance-led meetings with individual organisations throughout the year. In addition, national calls with NHS chief executives or their deputies, usually weekly, have been a feature of the Welsh Government's operational oversight of the NHS for many years.

222. In the earliest stages of the pandemic, these calls provided valuable insight into the very real and acute concerns in the system about the NHS being overwhelmed with

Covid-19 patients. System leaders were watching the situation unfold internationally, most notably in Italy and Spain, and it was clear from their feedback and concerns that urgent action needed to be taken to provide support and reassurance to the system.

223. As well as establishing the HSS Planning and Response Group to bring system leaders closer to decision making in Government (see paragraphs 181 and 182 of this statement), I established more frequent calls with system leaders to discuss pandemic preparation. These calls were regular, often daily, and more frequently when required, throughout the first phase of the pandemic response and then consistently throughout my tenure as Director General, HSS and NHS Wales Executive, although the frequency of these calls would inevitably track the progression of the virus and the different phases of the pandemic response.

224. It was clear from feedback received during these calls that urgent action needed to be taken to delay the onset of the pandemic to give the system time to prepare. This resulted in a formal request for support (see paragraph 230 below) and the decisions taken by the Minister for Health and Social Services in March 2020 (described in paragraphs 28 and 29 of this statement), which were co-designed with NHS system leaders during my calls with them.

225. This early action at the start of the pandemic translated, over time, into other key actions and decisions to support the NHS and to maintain its resilience, including the preparation of advice to the NHS and its constituent bodies, the planning and response plans for health and care, the Covid-19 action plan, and the first and subsequent quarterly operating frameworks. These actions are all described in detail in my corporate statement for the Health and Social Services Group, ref. **M2B/HSSG/01**, and I mention them here for the purpose of explaining how my regular (frequently daily, or more often than daily) dialogue with chief executives in the NHS in Wales guided and informed the decisions and actions that the Welsh Government took for the Welsh NHS throughout the pandemic.

226. These calls with NHS chief executives were an important channel of communication with the system throughout the pandemic. They provided an opportunity for me to disseminate information from the Welsh Government to the system, and to coordinate and mobilise specific action. They demonstrated visible leadership of a co-ordinated

response, and provided a facility for mutual support and cooperation between individuals and organisations working together as one NHS Wales.

227. They also provided me with invaluable intelligence and feedback from the system. This opportunity to listen to the system's concerns around emerging risks and issues, to hear their views on the mitigation measures necessary to respond to those risks, and their feedback on developing thinking within the Welsh Government put the NHS squarely at the heart of government decision making. It also meant that I was able to consistently articulate the NHS voice to ministers and at Cabinet, and provide a collective system view in my briefings and advice (as shown in the daily briefings exhibited at paragraph 127 of this statement). The resilience of the NHS and its outlook was always a key matter under consideration by Cabinet and through the 21 day cycle, and my advice was based on these system interactions and feedback.

228. While there were inevitably occasions during the pandemic when formal correspondence between me and the system, in both directions, was appropriate and necessary, these were supportive calls, open to insight and reflection from NHS organisations across Wales, and they provided the foundation for the collective way of working that we established throughout the pandemic response.

229. Ministers would join these calls occasionally, to hear direct feedback from the system, or to acknowledge the NHS' efforts at particularly challenging moments in the pandemic response, but these were first and foremost an operational tool instigated by me for the purpose of discharging my functions as the NHS Wales Chief Executive.

230. I was also able to liaise with the lead system chief executive, to hear the collective voice of Chief Executives, and this was a helpful supporting role that acted as a bridge between the Welsh Government and the NHS in Wales.

231. On occasion, we would instigate more direct contact with particular NHS bodies at a local level. For example, in advance of formally authorising funding for the establishment of field hospitals, the Minister for Health and Social Services and I visited Cardiff and Vale University Health Board at their proposed field hospital site at the Principality Stadium, to understand the scale of response required and the decisions that would need to follow.

232. Additionally, while most issues were raised via the regular NHS Wales chief executive calls, which I led, NHS Wales would raise issues more formally via correspondence to reflect a system view or request, either collectively or as individual organisations. One example of this is in the letter from the Board Secretaries Group, which I produce here as exhibit **M2B.WG.AG.01/045 - INQ000182552**. Another example of this is the letter from Carol Shillabeer, chair of the Chief Executive Group, in which she outlines the work of the NHS bodies in preparing for the pandemic and confirms the collective agreement among the Chief Executives that an immediate decision needed to be taken to enable a system reprioritisation of clinical and support service provision. I produce a copy of this letter as exhibit **M2B.WG.AG.01/046 - INQ000182388.**

233. Outside these collective structures, chief executives could approach me at any time, and I them, on any individual issues that arose of that were pertinent to their own organisations or concerns. This was a regular feature of my relationship with them, and the accounting officer responsibilities they held, alongside more personal relationships supporting them to discharge their roles.

NHS Wales Chairs

234. My relationships with the chairs of NHS Wales bodies were fundamentally different to my relationships with NHS chief executives. This was a consequence of the different accountabilities in the system: chief executives were directly accountable to me for the performance of their health bodies through their additional accountable officer roles, whereas the chairs reported on, and were accountable for, the governance of their organisations directly to the Minister for Health and Social Services.

235. Prior to the pandemic, I would meet with NHS chairs informally a handful of times a year, and I was always available to support them in their roles. They would also meet with the Minister for Health and Social Services quarterly, and I would attend those meetings to support the Minister. These meetings were retained during the pandemic and I would arrange these on behalf of, and attend in support of, the Minister.

236. During the pandemic, when I needed to consult the NHS chairs directly, I tended to invite them to join my routine calls with NHS chief executives, given that the environment was changing so quickly.

237. I valued and appreciated the chair's feedback, which helped with understanding potential areas of concern and where action was required and, while the NHS chairs did not form part of the Welsh Government's formal decision making processes, their feedback nevertheless helped to inform our understanding of the system.

Military Planners and Military Liaison Officers

238. Very early on in the pandemic, senior military planners were introduced into the Health and Social Services Group to provide planning support, logistics advice, operational support for the establishment of new services, and related support and assistance to the Welsh Government and NHS Wales. These senior military planners were embedded into the Health and Social Services Planning and Response Cell, which supported the HSS Planning and Response Group (see paragraphs 180 to 187 of this statement).

239. It was always clear that the military were not making decisions themselves but were a support mechanism for decisions and action that need to be taken by others. The reviews they undertook did feed into our operational decision-making. For example, they assisted with developing clear planning principles for NHS capacity so that we were able to prepare with urgency excess bed capacity in the NHS, leading to the establishment of field hospitals; the establishment of vaccination centres occurred with their operational support; and they assisted with more resilient ambulance response arrangements. They provided calm and rationale guidance on a range of areas, without overstepping any decision-making points. They also brought intelligence on military support activities, that would assist us in Wales.

240. On 26 March 2020, military liaison officers were also deployed into each of the seven local health boards, the Welsh Ambulance Services NHS Trust, and the Velindre University NHS Trust, in a variety of support roles ranging from planning to field hospital establishment and vaccination centre operations.

241. These military liaison officers provided NHS Wales with significant expertise and knowledge across a range of areas, including crisis response, logistics and construction, as well providing mentoring support to NHS Wales officials during the most challenging of times. This urgent offer of support and assistance was very much

welcomed, and military colleagues become trusted colleagues physically located alongside the NHS Wales leadership arrangements.

242. The formal involvement of these military planners and liaison officers came to an end in July 2021, but informal contact was maintained throughout the pandemic, with a view to re-establishing specific report if required.

243. I would like to take this opportunity to express my sincere gratitude to the armed services in Wales, and to the individual officers who supported the work of the Health and Social Services Group and NHS Wales throughout the pandemic. They played a variety of roles through this time: identifying points of concern and offering advice; helping to create national consistency in planning requirements, including for NHS capacity; enhancing ambulance response capability; reviewing logistics arrangements including for personal protective equipment and vaccination; embedding themselves in response groups and supporting on the ground implementation with urgency; and specifically supporting the development of field hospital capacity across Wales. They provided expertise and a reference point for critical decisions as well as offering coaching support to colleagues in these exceptional times. They also became part of our internal arrangements, with invitations to observe Ministerial and stakeholder meetings when relevant to their activities. They were highly regarded in all their activities, but were particularly influential and supportive in the fast-moving environment of 2020 and the first two waves of the Covid-19 pandemic.

Welsh Partnership Forum

244. The Welsh Partnership Forum for the NHS in Wales is a tripartite group, sponsored by the Welsh Government. It consists of representatives from: -

244.1. the recognised healthcare trade unions and professional organisations for NHS Wales;

244.2. representatives of senior management for NHS Wales; and

244.3. representatives from the Welsh Government.

245. This representation was reflected in the leadership of the Welsh Partnership Forum, and meetings were co-chaired by me, in my capacity as NHS Wales Chief Executive, a Union-nominated chair and an NHS chief executive.

246. The main purpose of the Welsh Partnership Forum is the development, support and delivery of workforce policies on a national, regional and local level. The Welsh Partnership Forum also provides strategic leadership on partnership working between employers and employee representatives across NHS Wales.

247. The Welsh Partnership Forum is involved in a wide range of aspects of healthcare delivery at a strategic level including, but not limited to: -

247.1. planning

247.2. education

247.3. recruitment

247.4. retention

247.5. development; and

247.6. support for NHS Wales staff.

248. The routine agenda fell away, somewhat, due to the need to pivot our focus to pandemic preparation response, but the forum acted as an important mechanism for communicating directly with frontline healthcare workers and their representatives, and for sharing developments and actions, and responding to areas of concern. The Forum provided an important opportunity to discuss workforce issues such as personal protective equipment availability and use, and vaccination and testing policies for the NHS workforce. While individual NHS organisations has their own structures in place for partnership working and collective bargaining at a local level, this forum was important for engaging with and hearing directly from the NHS workforce at a national level.

249. As I have mentioned previously, I spoke regularly with trade union colleagues throughout the pandemic, and I would also speak to trade union leaders and representatives in advance of significant decisions or actions being taken, in accordance with the Welsh Government's partnership approach to engaging with staff and their representatives.

250. This meant that leads were invited to come to participate alongside me to reflect on areas such as PPE availability and guidance, vaccination and testing. Individual NHS organisations had their own communication and structures with unions but this was an effective forum for common sharing and feedback.

Public Health Wales

251. Liaison with Public Health Wales, both formally and informally, was very much led by the Chief Medical Officer for Wales, Frank Atherton, given his overarching public health responsibilities and his role as the principal adviser to the Welsh Ministers on matters of population health. Frank also benefitted from established professional networks and close working relationships in the public health sector that he was able to deploy during the pandemic to bring public health advice closer to government.

252. The Chief Executive of Public Health Wales was directly accountable to me, as all NHS chief executives were, and I liaised with her and her team routinely, and upon request. However, I took care not to step into matters that were properly Frank's responsibility, or to create confusion or ambiguity around reporting and advice lines for ministers. I felt that ministers looked to Frank to provide the public health perspective, while I provided an NHS perspective, and Albert provided the social care perspective (alongside others of course). Consequently, most of Public Health Wales' work with and for the Welsh Government was coordinated by Frank, his deputy Chris Jones, and the office of the Chief Medical Officer.

253. Public Health Wales were already part of our collaborative healthcare system, and much of the work they did nationally informed and instructed the development of local outbreak plans by local health boards and NHS trusts. I also visited Public Health Wales early in the pandemic, to better understand their gold coordinating arrangements, and their contact tracing regime, ahead of the first confirmed case in Wales. I also liaised with them on testing capacity more routinely, as this had significant

consequent impacts on the NHS' ability to plan and prepare for the pandemic, and to respond to anticipated demand.

254. Public Health Wales also supported the Welsh Government's and the Senedd's scrutiny functions, and I recall my first attendance at the Senedd's Health and Social Services Committee during the pandemic with the Chief Medical Officer, which was also supported by a clinical colleague from Public Health Wales.

255. There was inevitably a need for the Welsh Government and Public Health Wales to closely coordinate their activities, and their communications, but to the best of my recollection this worked well, and I know that colleagues within the Health and Social Services Group and Public Health Wales were in regular contact to ensure clear and consistent messaging for the public. Public Health Wales also helped inform and guide our learning throughout the pandemic. For example, I recall brokering some meetings between the Minister for Health and Social Services and Public Health Wales following the first wave of Covid-19, to reflect on learning during that first phase and to share insights on how communication and briefings could be improved.

Other partnerships

256. I have been asked to address my role and participation in a very large number of bodies, committees, councils and forums through which the Welsh Government participated in partnership arrangements with a range of bodies, partners, and stakeholders. I have called out, in preceding sections of this statement, those forums that were the most significant in my role as Director General, HSS and NHS Wales Chief Executive. However, for completeness, I summarise briefly below my involvement with other forums specifically referenced in the Request.

Shadow Social Partnership Council

257. The Shadow Social Partnership Council is intended to facilitate discussion across the Welsh public sector on a range of strategic issues relating to fair work and social partnership. The Shadow Social Partnership Council is chaired by the First Minister, with other ministers attending where necessary. Membership of the Shadow Social Partnership Council also comprises 25 senior representatives from across the

devolved public services, the private sector, the trade unions and the voluntary sector, as well as the various Welsh Commissioners.

258. While I would attend meetings of the Shadow Social Partnership Council, by invitation and when issues relevant to my portfolio responsibilities were on the agenda, I didn't routinely attend these meetings. During the pandemic I, or other officials from within the Health and Social Services Group would attend when needed to give an overview of the NHS's status, the pandemic response in the health and care sectors, and the progression of Covid-19.

Partnership Council for Wales

259. The Partnership Council for Wales was established under section 72 of the Government of Wales Act 2006 to support joint working between the Welsh Government and local authorities in Wales. Its membership includes Welsh Ministers and representatives of county borough councils, county councils, community councils, national park authorities, police and crime commissioners, and fire and rescue authorities. I didn't routinely attend these meetings, but I or other officials from the Health and Social Services Group would have attended when invited to provide an overview of the pandemic response in the health and care sectors, and the progression of Covid-19.

260. Close liaison with our local authority partners in Wales was obviously crucial to supporting and overseeing the pandemic response in the care sector. However, I very much relied upon and trusted Albert Heaney to lead on those arrangements, which were coordinated through the Social Care Cell of the HSS Planning and Response Group which he led. Albert already had well established structures and relationships in place with the directors of social services across the twenty-two local authorities in Wales, and he effectively strengthened and supplemented these with additional support mechanisms as needed (as he explains in his statement to the Inquiry ref. **M2B/CSSO/01**). While I was available to support Albert as needed, I relied upon his experience in expertise in the sector, recognising that he was best placed to understand how to support our partners in this sector.

261. The Welsh Local Government Association is a participating member of the Partnership Council for Wales and was also invited to observe and advise Cabinet meetings from

the early days of the pandemic. Consequently, I would frequently see and hear from Andrew Morgan, the political lead for the Local Government Association at meetings of the Cabinet and, similarly, he would hear my briefings and advice to the Cabinet on the position in respect of health and social care.

NHS Wales Shared Services Partnership

262. The NHS Wales Shared Services Partnership was established in November 2010 to provide professional, technical, and administrative services for and on behalf of NHS Wales, and services to GP practices, dentists, opticians, and community pharmacies in Wales. The NHS Wales Shared Services Partnership is hosted by Velindre University NHS Trust, and it is accountable to me and to local health boards, NHS trusts and special health authorities through the Shared Services Partnership Committee.

263. Day to day oversight of the NHS Wales Shared Services Partnership was undertaken by Velindre University NHS Trust, and the Shared Services Partnership Committee. However, the Director of Shared Services joined the NHS Wales Executive Board and my calls with NHS chief executives, which provided a mechanism for close liaison with the Shared Services Partnership.

264. I would also meet directly with the Director of Shared Services when needed, or on issues of concern, or when my express authority was required in my role as Accounting Officer for NHS Wales for large procurement exercises, such as those undertaken for the supply of personal protective equipment during the pandemic.

265. I was, however, pleased that our historical decision to have a national shared service infrastructure and leadership, including national procurement, acting on behalf of organisations across Wales, helped support our planning and delivery during the pandemic response.

Wales Resilience Forum

266. As NHS Wales Chief Executive, I was a member of the Wales Resilience Forum. My role was to represent NHS Wales on behalf of the health bodies and provide a coordinating voice for the health system, alongside the Welsh Ambulance Services NHS Trust and Public Health Wales. I was in attendance due to my line management

responsibilities for NHS Wales as well as my oversight of Health preparedness internally as DG.

267. The Wales Resilience Forum is fundamentally a planning body, with no specific response function under the Pan Wales Response Plan. Consequently, it was not involved in making, or providing advice on, decisions regarding the Welsh Government's response to the Covid-19 pandemic.

268. The Wales Resilience Forum only met once during the pandemic, on 21 December 2021; a meeting I attended in my capacity as Permanent Secretary.

Local Resilience Forums

269. I was not a member of any of the Local Resilience Forums in Wales, and their arrangements were overseen by Reg Kilpatrick.

The First Minister's Black and Minority Ethnic Covid-19 Advisory Group

270. I was not personally a member of the First Minister's Black and Minority Ethnic Covid-19 Advisory Group, although I know that officials from the Health and Social Services Group and the wider Welsh Government Civil Service were.

271. I was, however, very interested in the reports that the Group produced, which were milestone moments in our understanding of the impact of Covid-19, that prompted us to review and adapt our pandemic response arrangements to address the issues identified by the Group. I particularly recall carefully digesting the Group's outputs and listening to their presentations to Cabinet and at other meetings of civil servants across the Welsh Government.

272. Much of the work that the Group undertook during the pandemic informed the Welsh Government's Anti-racist Wales work and plan, which I have taken on the mantle of leading in my role as Permanent Secretary.

The First Minister's Black and Minority Ethnic Covid-19 Scientific Subgroup

273. I was not a member of this Group, but I was particularly eager to learn from the Group's work. The black and minority ethnic workforce risk assessment group, led by Kesh

Singhal, was hugely influential and critical in our development of risks assessments of healthcare and other work environments. While I wasn't directly involved, I oversaw the products that were developed as a result of that work and I and my colleagues across the Health and Social Services Group ensured that these were rolled out across NHS Wales.

274. Our work embedding this risk based approach in NHS Wales became a template that other sectors subsequently adopted.

Other equality forums

275. I was not a member of the Disability and Equality Forum.

276. However, in making decisions for the NHS in Wales, the Welsh Government would seek to engage with the NHS Centre for Equality and Human Rights and the All-Wales NHS Equality Leadership Group, as well as others where possible to ensure that appropriate consideration of equality issues was at the heart of our decision making.

Professional and clinical groups and networks

277. There were, of course, many clinical and professional groups, bodies, and committees that were part of the NHS' routine infrastructure, that continued to meet throughout the pandemic, and that provided further points of contact with the system, and an opportunity to gather information and evidence about the system's capacity and resilience. Examples of these include the clinical advisory groups, clinical networks, meetings with professional clinical bodies such as the Royal College of Nursing and the British Medical Association, and meetings with the various commissioners for Wales.

278. Given the specific roles and responsibilities of officials within my team, most notably the Chief Medical Officer for Wales, the Deputy Chief Medical Officer for Wales, and the Chief Nursing Officer for Wales, much of the routine contact with the professional bodies and networks would be led by the appropriate professional lead in the Health and Social Services Group. The feedback provided by these professional and clinical networks would always form part of my discussions with the relevant directors.

279. However, at key moments I, with the support of my team, would often speak directly to groups like the British Medical Association, BMA Cymru, the Royal Colleges, and the trades unions to test potential decisions and actions, and to check-in to ensure that they were fully informed about the decisions and actions being taken. These conversations were often outside the formal meeting infrastructure, but they were an important part of my reaching out in Wales, and ensuring that our 'no surprises' philosophy extended beyond our executive level discussions out across the system.

Health and care system regulators

280. I would also maintain regular contact with the health and care system regulators (Health Inspectorate Wales, Care Inspectorate Wales, and Audit Wales) given the important regulatory function they discharged which continued throughout the pandemic, for the purpose of open communication and understanding, and to understand their revised approaches to their safety and regulatory roles.

UK collaboration

281. Much of the Welsh Government's formal collaboration with the UK Government and the other devolved governments was led either by the First Minister or the appropriate Welsh Minister, or by those Welsh Government officials who naturally had a role to play on cross-cutting, or cross-jurisdictional professional or technical matters. I understand that the Chief Medical Officer, the Deputy Chief Medical Officer, the Chief Scientific Adviser, the Chief Scientific Adviser for Health, and the Chief Nursing Officer for Wales all regularly participated in UK-wide meetings and groups, and in discussions with their counterparts in the other UK nations.

282. My contact with my UK counterparts was naturally more limited. I did have discussions with my NHS Chief Executive colleagues for England, Northern Ireland, and Scotland, for the purpose of collaboration and information sharing, and these meetings were generally positive with good engagement, and a mutual sharing of intelligence, strategies and activities. There were also reciprocal agreements to provide mutual support, if required, across our boundaries. However, these were not decision making meetings.

283. Immediately after Wales decided to step down non-essential NHS activity to support preparation for the pandemic (see paragraph 28 of this statement), I shared this intent with colleagues in the other devolved governments, who through their own decision making processes followed soon after.

284. I would also, by invitation, attend Ministerial Implementation Group meetings with the Minister for Health and Social Services, although the Chief Medical Officer and Deputy Chief Medical Officer attended these meetings more routinely than I did, noting the focus on advice and policy.

285. My officials in the Health and Social Services Group also liaised closely with key individuals and teams at a UK level and in England, Northern Ireland and Scotland, for example in relation to the vaccination programme, and the supply of personal protective equipment. I was perfectly happy for this liaison to take place with the right people, at the right level, with my permission and delegation, and this reflected wider working practices across the Group, where I would delegate responsibility for certain actions and objectives to members of my team but retain oversight over, and hold my team accountable for, delivery.

286. I would call out the vaccine roll out as a particular example of where we found the right balance between the UK Government's role in providing oversight over and procuring vaccine supplies, with the devolved governments responsible for organising the delivery of vaccines to their local population based on their needs.

287. In my experience, the relationships between our officials and their counterparts in the UK and the nations of the UK were always constructive, and available when required. While I was available to intervene, there was rarely a need for me to marshal specific arrangements or to intervene in existing relationships, which is a sign that they worked positively and effectively. I do recall speaking with Emily Lawson at the request of my team in respect of access to personal protective equipment for Wales, and I also spoke briefly with Clara Swinson at her request. These discussions were always constructive and supportive. However, much of the senior liaison across the Civil Service was led by Shan Morgan, in her capacity as Permanent Secretary, including liaison with the Permanent Secretary at the Department for Health and Social Care. However, I did provide briefings for Shan on issues to consider and raise in those meetings, at her request.

288. I was not directly involved with COBR or its subgroups. I did listen in on some of the extended COBR meetings, and other UK meetings that took place remotely, particularly during Autumn 2020 when an extended audience was permitted to join these calls.

289. I was also not directly involved with Public Health England or the UK Health Security Agency, as those engagements tended to be led by other Welsh Government officials and Public Health Wales. I did participate in a brief exchange of correspondence following the establishment of the UK Health Security Agency, and recall meeting with Dame Jenny Harries, through which I sought to confirm my understanding regarding its accommodation for Welsh requirements, and the liaison points with Wales.

The initial response period: January 2020 to March 2020

290. I have provided several detailed accounts and chronologies to the Inquiry, in my previous statements. My corporate statement on behalf of the Health and Social Services Group, ref. **M2B/HSSG/01**, in particular describes the work of the Health and Social Services Group, under my leaderships, during this period and I would refer the Inquiry to that rather than repeating that detailed evidence here.

291. At the start of the pandemic, when news of the situation in Wuhan began to emerge, the Chief Medical Officer, Frank Atherton, in conjunction with public health officials at Public Health Wales, led on monitoring the international situation and assessing the public health situation in Wales and the rest of the UK.

292. I was copied into daily briefings that were provided to the Minister for Health and Social Services from around 28 January 2020. I also remained in close contact with Frank Atherton throughout this period, as I respected and trusted his expertise and professional judgment on the emerging situation, which in turn informed the actions that I took during this period.

293. My focus, during this initial period, was on establishing the structures that would be necessary within the Health and Social Services Group, and across the wider health and care sectors, to respond to the emerging public health emergency. I explain at 180 to 181 of my statement, the steps that I took to stand up planning and response arrangements within the Group, both internally and engaging outwardly with the

system. I also explain at paragraph 221 of my statement, the steps that I took to engage directly with leaders in the health system, and at 28 to 29, the steps that I recommended to the Minister for Health and Social Services, in consultation with NHS system leaders, to help the NHS to prepare.

294. Feedback from the health system was very clear during this initial period that there was genuine concern that the NHS might be overwhelmed with Covid-19 patients, and that urgent action was required to delay the onset of the pandemic to give the system time to prepare. I worked closely with the Minister for Health and Social Services to agree and implement the actions necessary to delay the pandemic's onset in Wales, for the purpose of providing necessary support and reassurance to the system, and ensuring that necessary preparations could be completed that would ultimately allow the system to meet the needs of those who needed it.

295. At the same time, Albert Heaney was taking urgent steps to engage with leaders across the care sector to understand their concerns and needs, and to step up arrangements to coordinate the social care response through his Directorate (and I refer the Inquiry to his statement ref. **M2B/CSCO/01**).

296. On 28 February 2020, the first case of Covid-19 in Wales was confirmed. I recall this day very clearly, as Frank Atherton and I had been discussing the potential for a first case in the period leading up to this confirmation, following a number of suspected cases that were subsequently confirmed negative during February. I vividly remember speaking to Frank while he was waiting at Bristol Airport to travel to Northern Ireland. We agreed that Frank should immediately return home, to support ministers and to reassure the public.

297. On 3 March 2020, only 3 days after the first confirmed Welsh case, a joint action plan between the UK Government and the devolved Governments in Wales, Scotland and Northern Ireland was published, 'Coronavirus action plan: a guide to what you can expect', which I produce here as exhibit **M2B.WG.AG.01/047 - INQ000066061**.

298. On 4 March 2020, I attended a meeting of the Cabinet with Frank Atherton, Chief Medical Officer for Wales and Albert Heaney, then Director of Social Services and Integration. The Chief Medical Officer for Wales was in the prominent position of acting as adviser to Cabinet and the First Minister at this point, noting the public health status

and trajectory and the need for a clear and common understanding of the emerging situation. My role was to support the Chief Medical Officer in his advisory role, to advise and lead any health department functions and roles in these circumstances and to focus on the leadership of NHS Wales.

299. Very quickly my role developed to one of adviser to the Cabinet, alongside Frank and the Permanent Secretary, most notably in terms of my NHS leadership role. Ministers required me to have a clear understanding of the system's capacity and preparedness, and to feed this into the Welsh Government and ministerial decision making structures. I believe that this was because of my experience and the confidence in me, not just because of my specific role. I had worked closely with both the Minister for Health and Social Services and the First Minister over many years, and built a strong relationship which, I felt, was built on their trust in me and confidence in my judgment at critical points.

300. However, I was always conscious of the need to respect the other experts around the table, notably Frank Atherton, but also Rob Orford and Fliss Bennee as co-chairs of TAG and TAC (which had by this time been stood up), and to be clear with ministers who was best placed to provide advice and support across the full range of responsibilities within the Health and Social Services Group.

301. On 4 March 2020, I attended a closed session of the Health, Social Care and Sport Committee with the Minister for Health and Social Services, the Chief Medical Officer for Wales and an official from Public Health Wales to provide a technical briefing for Members of the Senedd. This briefing was instigated on my and Frank's advice and at our request, and it began a regular cycle of technical briefings to the Committee, both publicly and in closed session, in order that Members of the Senedd were able to discharge their governance and scrutiny function throughout the pandemic. Senedd Committee sessions are usually open however the Senedd's Standing Orders, order 17.42(vi) provides that a committee may resolve to exclude the public from a meeting or any part of a meeting where the committee is deliberating on the content, conclusions or recommendations of a report it proposes to publish; or is preparing itself to take evidence from any person. A motion under Standing Order 17.42(vi) had been made by the committee on this occasion.

302. This part of my role developed significantly over the coming months, both in terms of the advisory role I played at Cabinet and for the First Minister and the Minister of Health and Social Services, and the public role I played communicating our pandemic preparations and response to the public through press conferences and media interviews. I refer the Inquiry to exhibit **M2B.WG.AG.01/004 – INQ000350744**, a chronology of the press conferences I attended during the pandemic.

303. In March 2020, modelling for NHS Wales projected a necessity for 900 critical care and an additional 10,000 system-wide beds at the point of peak demand. It should be borne in mind that the existing capacity within NHS Wales was only 152 critical care and 7,839 system-wide beds as at the end of January 2020. This scenario was based on a 40% reasonable worst case scenario and, given the then rate of transfer, it was anticipated that Wales would see peaks in demand over the next 3-4 weeks. This reasonable worst case scenario modelling indicated that NHS Wales' capacity would be significantly exceeded, as over half the population of Wales would become symptomatic, with a high proportion of those contracting the virus requiring hospital care, including ventilation, and serious infection resulting in excess deaths.

304. Whilst we could have left it to individual organisations to assess and calculate their own capacity requirements, whether enhancing existing capacity or creating significant new capacity like field hospitals, we felt it important to own this nationally and set expectations for the forthcoming weeks and to fast track the responses, rather than divert attention with further local assessments.

305. On 12 March 2020, I attended a meeting with NHS Wales chief executives to discuss the urgent actions that needed to be taken to protect the NHS.

306. On 13 March 2020 I attended a press conference with the First Minister and the Minister for Health and Social Services to explain the actions we were taking to prepare NHS Wales. I recall that this press conference was very visible in Wales, and caused some shock among the population. The Minister for Health and Social Services chose to disclose information based on the modelling that we had seen, to emphasise the scale and seriousness of the threat posed by Covid-19, and to contextualise the actions that were likely to follow in the coming weeks.

307. On 18 March 2020, Samia Edmonds issued the COVID-19 preparedness and response: guidance for the health and social care system in Wales. The document was produced 18 days after the first Wales case and 7 days after the WHO declaration of pandemic status for coronavirus. 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 and social care agencies in Wales, while providing an overview of the whole system response at both national and local levels.

308. On the 20 March 2020, the Minister for Health and Social Services was asked to agree to the early handover to Aneurin Bevan University Health Board of parts of the new Grange University Hospital. This was anticipated to provide up to 350 additional beds to support lower acuity patients by the end of April 2020.

309. On 23 March 2020, the national lockdown was announced, and the First Minister made a statement in the Senedd on the measures that would be taken in Wales. I felt that this was absolutely the right thing to do, as we were in parallel working on NHS actions, plans and responses to mitigate the highest level of demand forecast, and leading on proposals such as increased critical care capacity and the establishment of field hospitals. However, I still remember being shocked by how quickly the situation had escalated, and how quickly governments had responded to the first cases and instigated the lockdown. After all, it had been scarcely three weeks since the first confirmed Welsh case.

310. On 26 March 2020 I participated in a remote press Q&A with Frank Atherton, Chief Medical Officer for Wales to discuss the pandemic progression in Wales, the preparatory actions being taken to build capacity and resilience in the NHS, and testing.

311. I recall during this period that we were closely tracking and monitoring the development of the virus, initially from an international perspective and through the lens of the WHO, converting this into a more UK and then Wales-led analysis as we saw the first confirmed cases emerge. Our emergency planning guidance for pandemic flu highlighted the importance of these initial monitoring phases, and I do think we were recognising the seriousness and potential scale of the pandemic from very early on in the pandemic, particularly when you consider that the Coronavirus Action Plan was

issued within 3 days of the first confirmed Welsh case, the NHS had pivoted to shoring up essential services within 13 days, and we were fully locked down within 3 weeks.

312. In the context of the NHS, I think we acted very quickly to stand up our emergency arrangements, to instigate regular contact with the system to understand and test capacity, and preparedness, and to identify the actions that needed to be taken to delay the onset of the pandemic to afford the system the time it needed to prepare. Particular when you consider that the virus was novel, and that we knew so little about it or its potential transmissibility, and effects. There were some very honest conversations with the system about its preparedness during this period, and we used our (often more frequently than) daily calls to work through the implications of the demand modelling and mitigation to avoid the levels of excess of deaths that the modelling was predicting in Wales. We were also watching the reality of these modelled effects playing out through the rolling news coverage of the health systems in Italy and Spain.

313. The NHS was concerned that even with the best plans, and increases to available capacity and contingency measures, the healthcare system would have been very quickly overwhelmed. We did however continue to work at pace on our plans to expand capacity for NHS beds and critical care, create flexibility in our workforce plans if needed, and to define essential activities for the NHS to support. We also initiated plans to create alternative contact points for the population at scale, such as video consultation platforms, that due to urgency were established in a matter of days and weeks.

314. I have been asked to give my opinion on whether contain, delay, mitigate and research was an appropriate strategy during this period. At the time, noting the emerging data and evidence, and even the phasing of approaches in our pandemic flu plan, and recognising the public health advice that was available to us at that time, we were drawing on previous experiences and using that with good intentions. The contain, delay, mitigate approach was an early translation to coronavirus from our previous emergency preparedness approaches and in simple terms this gave us a structure to follow at that stage, subject to later changes and adaptations as we learnt more about the virus.

315. In hindsight, we had perhaps not fully appreciated the scale and seriousness of the actions that were taken, particularly in terms of the nature of the society-wide restrictions that were imposed. These were unprecedented steps and beyond even actions previously reviewed in our exercises; lockdown did not feature as a likely action within those plans. As I recall, it was clear there was something different in pandemic coronavirus, in that we knew early on that that we did not have the first level mitigations, treatments and response options that would have been available in a different pandemic scenario, that we had planned for. There were so many aspects of coronavirus that were simply unknown.

316. The biggest mitigation that ultimately slowed down the spread of the virus and reduced the impact on the NHS, and the potential for it to be overwhelmed, was lockdown and the constraints on movement and social interactions in society that accompanied it. In hindsight, given what we know now, while I would like to think that this decision could have been made earlier with no or smaller numbers of UK and Welsh cases, I'm not convinced that this measure, given its unprecedented nature, would have been accepted by the population if it had been imposed when the number of confirmed cases was only very small, and to impose such measures without any confirmed cases feels too much of an assumption in hindsight.

317. Even now, when we can show the impact of minimising social interactions and the positive benefit it had to slow transmission, minimise the overall number of deaths and allow the NHS to remain resilient, we know there are many who believe lockdown shouldn't have happened, and that other harms should have been afforded more weight in the difficult balancing exercises that needed to be undertaken. Given this would, in my view, have led to more health harm and more deaths in Wales this is not my view. The exponential progression of the virus made it very challenging to keep up with the development of cases across Wales and the impact of that, and we were often taking decisions to respond and mitigate that would affect case numbers three weeks on, and not for the immediate period. This was difficult to communicate and convey as time was needed to show that actions had the desired impact, and this may at times have created some anxiety and uncertainty in the population.

318. We used our existing plans as the basis for our emergency planning response, and we did follow the preparation phases of the Pan Wales Response Plan, which required us to track and monitor the public health developments. While I do not recall us specifically

deciding to formally trigger the Pan Wales Response Plan, this plan did inform and form the basis of much of our action during this initial phase. During February 2020, we introduced aspects of the plan e.g., by establishing the Emergency Control Centre Wales, the health intelligence cell, and a health planning and response infrastructure. The Plan included scope for Emergency Control Centre Wales to be set up but not formally activated under the Pan Wales Response Plan to enable it to act as a crisis management centre for the Welsh Government. In my view, this was generally a positive feature of our response. For example, we were only able to pivot the NHS to providing essential services to enable it to prepare for the pandemic so quickly because we were able to draw on the extant pandemic flu planning documentation and adapt it appropriately to the circumstances we faced. In terms of why a decision was not specifically taken to formally trigger the Pan Wales Response Plan, the plan itself requires that decision to be taken by the Welsh Government in conjunction with the UK Government and Category 1 or 2 responders (as defined in the Civil Contingencies Act 2004). At the time the four nations were working on a public health response specific to Covid-19, as opposed to a civil contingencies response.

319. I don't recall the phrase 'herd immunity' being part of our routine language, but of course the underlying assumptions to ensure population resilience formed part of our pandemic flu planning. However, I do wonder if the term came to be used inappropriately and misunderstood during the initial phase of the pandemic. Herd immunity is generally a specifically understood and positive term that is used to describe vaccination and immunisation approaches for populations, reflecting a level of population-wide immunity where the general level of vaccination limits the spread of disease in that population. I don't recall a specific discussion about herd immunity, or any circumstances where I gave advice on it. However, others who were more intimately involved in the public health advice provided to the Welsh Ministers would be better placed to provide evidence on this matter.

320. The use of the reasonable worst case scenario modelling data and scenarios were fundamental in supporting the range of decisions and actions that were taken during this initial phase and throughout the first wave of the pandemic. In hindsight our previous pandemic flu experiences including the lessons learnt from the Swine Flu pandemic and the exercises undertaken at that time which indicated that the reasonable worst case scenarios tended to overstated the impact but, in fact, the reverse was true for Covid-19 and we quickly learned how important it was that the

reasonable worst case scenarios were accepted as the most likely to be borne out in practice. These scenarios, translated into a clear impact profile for Wales in terms of cases, admissions and deaths, required urgent response and action and set the context for how mitigating actions would be implemented, particularly given the NHS' early experience showed us that treatments provided little benefit, nor was there access at that point to vaccination.

321. The scenarios adapted over time during the progression of the virus, but during the first wave we shared the expected impact publicly and we set the planning assumptions for the NHS based on the scale and severity of impact on these assumptions also.

322. Due to the decisions taken, most notably lockdown, the expected cases did not emerge nor the highest levels of predicted deaths, although there were very significant impacts across Wales that affected people, families and communities. Nevertheless, the mitigating actions that we took did limit and reduce the risk of exponential growth of the virus that would have led to these forecasts being borne out in practice. In hindsight, there is a danger of thinking these numbers would not have happened, but in the early weeks of the pandemic our own numbers were closely tracking the pandemic modelling rates, and the reasonable worst case scenario, and this would have been very real.

323. Our later modelling was influenced by this experience, which taught us to positively trust the data and the NHS operational tracking produced with our methodology, including expert modelling support from TAG and Swansea University.

324. Given the reproduction rate reduced and cases along with it, this initial phase gave us confidence that mitigating actions could work to limit the spread and harm to the Welsh population. This set the content subsequently, in my view, for a more precautionary approach to protecting the Welsh population as the pandemic progressed.

Test, trace, protect

325. Test, trace, protect was a crucial part of the Welsh Government's approach to limiting the spread of Covid-19. The Test, Trace, Protect programme was developed rapidly from scratch through the partnership arrangements with NHS Wales and local

authorities, which were put in place at the start of the pandemic. Test, trace, protect in Wales had national oversight from the Welsh Government but was heavily reliant on the technical expertise and experience that sits within Public Health Wales, local health boards, local authorities, the third sector and the NHS Wales Informatics Service. It was based on a nationally overseen, but locally delivered, model which increased its effectiveness and performance.

326. At the end of March 2020, Ministers agreed the National Covid-19 Testing Plan developed under the direction of Rob Orford and with input from with a range of stakeholders and experts, which I produce here as exhibit **M2B.WG.AG.01/048 – INQ000215237**.

327. However, throughout March and April 2020, the Welsh testing programme was significantly constrained by the availability of both antigen and antibody tests. These difficulties are described in detail in the statement of Jo-Anne Daniels (ref. **M2B/WG/JAD/01**[7]), whom I had asked to take on the role of Director for Test, Trace, Protect on 24 April 2020. At that time, the Health and Social Services Group was engaged in 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. Jo-Anne was an experienced senior civil servant and director with a proven track record of bringing stakeholders together to deliver complex projects. I felt that her particular skills and experience were ideally suited to leading this complex, collaborative project. I explained to Jo-Anne that she had my authority and support to take necessary actions, and I immediately informed NHS chief executives and NHS Wales that I had appointed Jo-Anne to undertake this work.

328. I tasked Jo-Anne with rapidly scaling up our testing capacity in Wales, and she set about carrying an urgent review of existing capacity, and putting necessary actions in place to rapidly increase capacity. The programme she developed included integrated testing capacity and capability under the wider UK National Testing Programme alongside specific Welsh testing sampling sites run by local health boards, processed at NHS Wales laboratories and sequenced by the PHW Pathogen Genomics Unit. This

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[7] See, in particular, paragraphs 33 to 41 of that statement.

approach provided us with the ability to scale up wider population testing alongside prioritising testing within the Welsh system for critical workers, patients and in response to localised outbreaks.

329. Early testing capacity was clearly an issue, and while Public Health Wales took early action to commence contact tracing and stepped up their gold command arrangements to discharge their first responder function, they were impaired initially by a lack of available tests.

330. Obviously, sustaining the response in the face of increased demand became more difficult as the weeks elapsed although in the initial phase there was still variation in the pattern of transmission across local authority areas that would have least assisted with the management of this demand.

331. I felt that our colleagues in Public Health Wales, in liaison with stakeholders, discharged an effective role in these early weeks and were essential in supporting our understanding of the risks and progress of the virus. However, the critical moment came when volume and demand exceeded the ability of the initial contact tracing process. While this could have been expanded with increased capacity, ultimately the limiting factor was the availability of sufficient tests to maintain general public testing, and we needed to prioritise tests for symptomatic patients, and those in health and care settings.

332. In hindsight, if testing capacity had been available, I believe that despite the extraordinary ask it would have represented, maintaining a universal contact tracing system may have more positively affected outcomes over the subsequent weeks of the pandemic. Of course this was revisited and reintroduced later through our Test, Trace, Protect mechanisms, but the decision-making and progress was significantly affected by insufficient testing capacity Ultimately, our laboratory capacity across the UK did not have the infrastructure in place to rapidly expand; subsequent decisions we made to expand and invest in capacity highlight this weakness in our response arrangements.

333. In respect of the more technical aspects of Test, Trace, Protect, Jo-Anne Daniels will be best placed to assist the Inquiry.

Shielding advice

334. Work on the advice provided to clinically extremely vulnerable on shielding was led by the Chief Medical Officer, Frank Atherton. While I retained oversight over this process, as Director General, HSS, I was not directly involved in the production of this advice as it required clinical input that was best facilitated by Frank and his team.

335. I recall that the process of developing first categories of people who should be classified as clinically extremely vulnerable for inclusion on the shielding list, and the lists of individuals patients who should be included on that list, was technically complicated and required input from a range of different partners, stakeholders and data sources. I understand that the Chief Medical Officer for Wales worked collaboratively with his colleagues across the UK to develop consistent clinical criteria for inclusion on the shielding list, and with NHS Wales and primary care colleagues to apply those criteria in line with our data sources and technical judgments. NHS Wales Informatics Service also worked closely with the Chief Medical Officer on the significant data processes that needed to be developed to identify individuals within each of these categories and to deliver protective shielding in practice, and that a lot of careful planning and preparation went into ensuring that the local model of delivering support to people who were shielding worked effectively. This work on local implementation would have involved my colleagues in communities and local government, who would have been responsible for much of the practical implementation of our protective shielding measures.

336. In my experience, this was typical of the Welsh Government's response. We tended to take a little more time to plan and prepare, to ensure that our proposed actions could be delivered effectively on the ground, in our communities, before announcing them, but this early and diligent preparatory work tended to mean that we experienced fewer issues with our implementation.

Face masks

337. The wearing of face coverings, as a public health measure, was primarily the responsibility of the Chief Medical Officer, Frank Atherton. However, I understand that the Nosocomial Transmission Group, led by the Deputy Chief Medical Officer for Wales, Chris Jones and the Chief Nursing Officer for Wales, Jean White, were also

involved in developing guidance on the use of face coverings in health and care settings.

338. I recall that Frank had a clear view that face coverings had limited impact on transmission of the virus. Of course, there was a stronger evidence base for the use of face masks in clinical settings, where it was generally possible to be more confident that they were used correctly, fitted properly, and disposed of at the appropriate time. On the balance of the evidence now available, I'm still not personally convinced that face coverings are an effective way of limiting general community transmission, particularly when you consider the fact that many face masks are not of clinical quality, are ill-fitting, people frequently wear them more than once, and take them on and off regularly. However, there were positive aspects of the widespread use of face masks. They were a very visible, and in many ways visceral, reminder of the presence of the virus in our communities, and the need to take sensible precautions, like socially distancing and good hand hygiene and I felt that this was a behavioural signal. Conversely, there were occasions where people wearing masks would not respect social distancing guidelines, so there was also a risk that they could create a false sense of safety. My own view of our advice was that face coverings played more of a function to prevent people who may potentially be covid positive transmitting the virus to others, as a personal decision of an individual to protect others, rather than the most effective mechanism to protect an individual. As I'm not a public health expert, or a behavioural scientist, I'm probably not equipped to give a definitive view on the relative merits and demerits of wearing face masks. Suffice to say, that so far as I am aware the evidence either way is less than compelling.

Procurement and supply of personal protective equipment

339. I explain the role that Health and Social Services Group officials played in the procurement and supply of personal protective equipment in my corporate statement ref. **M2B/HSSG/01**, and I refer the Inquiry to that evidence.

340. Officials across the Health and Social Services Group played an important role in securing the procurement and supply of personal protective equipment, despite the fact that arrangements were already well established in both health and social care for routine procurement to be led by, and take place within, the health and care sectors.

341. Early on in the pandemic, health professionals in the Health and Social Services Group provided advice and guidance on the need to prioritise the procurement, supply, and use of personal protective equipment in a variety of clinical and care settings. This advice routinely drew upon advice provided by UK groups, with the specific intention of ensuring a consistent approach, and was largely led through the Nosocomial Transmission Group which provided guidance on the use of PPE in a variety of health and care settings (explained in the statement of Jean White, Chief Nursing Officer for Wales, ref. **M2B/CNO/JW/01**).

342. Simultaneously, officials working through the HSS Planning and Response Group worked closely with the NHS Wales Shared Services Partnership, and the Velindre NHS Trust which hosted it, to understand how robust existing supplies and stockpiles were, and whether support was required to assist with the procurement and supply of personal protective equipment. At the same time, Albert Heaney and his team were liaising with local authorities, which were responsible for procuring their own personal protective equipment supplies for workers in the care sector, to understand whether additional support was required. Early decisions were taken to release personal protective equipment from the stockpiles held for Wales for use by GPs, and the wider health and social care sectors when required.

343. Arrangements were put in place quickly to allow social care providers to approach their local health boards for personal protective equipment upon a confirmed case arising in their care setting, while the Welsh Government established more formal arrangements.

344. The distribution of personal protective equipment to care settings was facilitated by the NHS Wales Shared Services Partnership, which distributed personal protective equipment supplies to the joint equipment stores that serviced local authorities. Over time, our distribution networks expanded to include individual health and care settings, such as GP practices, care homes, and pharmacies.

345. Alan Brace, Director of Finance, headed up the PPE Supplies Cell of the HSS Planning and Response Group, in part in recognition of the fact that the Welsh Government would need to make a significant contribution to the cost of PPE in these sectors, and to fund the procurement of sufficient personal protective equipment stockpiles. The Welsh Government committed significant sums to procuring additional personal

protective equipment for the health and care sectors, from a range of Welsh manufacturers, on international markets, and through mutual arrangements with other UK nations.

Discharging patients from care homes

346. I have explained at paragraphs 28 to 29 above, the circumstances that led to the Minister for Health and Social Services agreeing a framework of actions for the NHS in Wales, to enable it to prepare for the pandemic peak on 13 March 2020.

347. Those actions had been tested with NHS chief executives during a call with the Minister the previous day, 12 March 2020. I had also attended a meeting that day with the Minister and Albert Heaney, then Director of Social Services and Coordination, to discuss the implications for the social care sector of taking a number of actions to expedite the discharge of patients from hospitals to care homes, including the relaxation of certain targets and monitoring, the minimisation of certain regulatory requirements, and the suspension of the right to choice of home in order to fast track care home placement. The purpose of these actions was to facilitate the timely discharge of patients from hospital to a care home, thereby ensuring that hospital beds would be available for those in urgent need during the anticipated surge in demand linked to Covid-19. Our normal operational environment in discharging patients is to do so safely and appropriately.

348. The social care sector plays a critical role in the day-to-day resilience and capacity of the NHS in Wales. An inability to discharge patients out of hospital would very quickly slowdown NHS activity and limit capacity. We had been clear in guidance to the NHS on 13 March 2020 of the need to ensure capacity was freed up wherever possible, noting the decision to limit and divert other activities. The reasonable worst case modelling was showing that without available capacity, the NHS would become overwhelmed and be unable to carry out its functions, including for emergency and life threatening treatment.

349. We have emphasised the need for health and social care to work closely together, not least as A Healthier Wales represented a joint plan for health and care. We had given guidance already on removing the choice policy based on the principle that we needed to expedite discharge and have enhanced flow from the NHS to social care. All these

measures did create additional capacity and flexibility to be used in those early weeks when we saw levels of cases and admissions increase.

350. Given the increasing numbers of patients, potentially with Covid-19, coming intro hospitals we also needed to ensure that patients were not unnecessarily exposed to risk and if they were medically fit to be moved, they should leave hospital facilities. This principle was always based on safe discharge and that did not change throughout the pandemic.

351. At a simple level, if patients do not move from hospital to home or social care environments, then patients cannot be moved internally in hospitals, which means they cannot be moved from admission to A+E, which means that they cannot be transferred from ambulances. This flow and transfer of patients needed to be maintained and enhanced safely, in response to the likely requirements for NHS beds and capacity, as the NHS would very quickly have ground to halt even in these early stages of the pandemic.

352. We were also acutely aware that hospitals were themselves a high risk environment, due to the admission of new Covid-19 patients. While precautions were taken, the risk of a non-Covid-19 patient acquiring any infection, including Covid-19, increased with every day that they remained in hospital when they were medically fit to be discharged.

353. At that time, we were not aware of the risks posed by asymptomatic transmission and, as testing capacity was limited, tests were prioritised for those who were symptomatic or who had been in close contact with those were symptomatic, including health and social care workers.

354. We also believed that personal protective equipment would be effective in preventing transmission in health and care settings, and we had taken a number of steps to assure the supply of personal protective equipment to frontline staff in both health and care settings (see paragraphs 337 to 343 of this statement).

355. I understand that Albert Heaney explains the guidance that applied to care settings at this time, and in the period following in his statement ref. **M2B/CSCO/01** at paragraphs 51 to 75. However, my understanding is that the guidance in place at that time did not require a negative test prior to discharge of an asymptomatic patient to a care home.

356. I do not recall attending any meetings with my UK counterparts on this issue, although I understand that Albert Heaney did have meetings with a range of stakeholders on this issue during March and particularly April 2020.

357. With the benefit of hindsight, and the understanding we have now about the risks of asymptomatic transmission, we would have perhaps made different decisions about the discharge arrangements during this phase of the pandemic. However, officials at the time made the best decisions they could, with the information available to them at the time. Even with the benefit of hindsight, and all the learning we acquired during the whole pandemic, it is still difficult to see how, without an effective vaccination that both prevents serious illness and reduces transmissibility, it would have been possible to eliminate nosocomial transmission in health and care settings when community transmission rates were so high.

Data, scientific evidence and public health advice

358. I have been asked several detailed questions about the availability and use of data, modelling, and public health advice across the Welsh Government. While these matters all fall within my broad remit as Director General, HSS, I very much had trust and confidence in those scientific and public health experts within my senior team who led on these aspects, notably Frank Atherton, Chief Medical Officer for Wales, Rob Orford, Chief Scientific Adviser for Health, and Fliss Bennee, co-Chair of TAG and TAC, as I have explained above. I believe that they will be best placed to answer the Inquiry's questions on the availability, and use of data, modelling, and public health advice from, amongst others, Public Health Wales.

359. In the context of the NHS, where I played a more direct role in analysing and assuring capacity and resilience, I worked with the system to develop a range of reporting mechanisms that provided near real time data on capacity, that informed my briefings to ministers.

360. From 23 April 2020 the Welsh Government produced a weekly output of management information related to NHS activity and capacity, to support transparency and understanding of NHS activity through the pandemic and inform Cabinet decision making around the 21 day review points. This included data on critical care beds in use in Wales and the numbers for those invasive ventilated. The evidence

underpinning these outputs was collected by Digital Health Care Wales from local health boards. Statisticians in the Welsh Government's Knowledge and Analysis Service worked with Digital Health Care Wales 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. The Health and Social Servies Group also received daily SitReps from NHS organisations.

361. We also used system operational data to show trends and preparations for the likely peaks in covid demand, tracking the actual position visibly alongside modelling predictions. I believe this also gave confidence to the system and the broader population about understanding the trajectory of the virus and the level of preparations in place to respond.

362. HSSG officials also worked closely with the Welsh Government's Knowledge and Analysis Service 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 the vaccination programme.

363. In my experience, there was a very rapid development of statistics for us within the Welsh Government and much of this was shared directly in the public domain. It was important for me, in my oversight and assurance role, to be able to access and use operational data from NHS Wales to support my assessments for ministers, to support ministerial understanding and decision making.

PART B

Permanent Secretary and Principal Accounting Officer
1 November 2021 – 30 May 2022

My role and responsibilities

365. As Permanent Secretary, I am the principal policy adviser to the First Minister, Principal Accounting Officer, and Head of the Welsh Government Civil Service. I lead the Welsh Government Civil Service in supporting the First Minister and his ministerial team to realise their policy and legislative objectives. I am line managed by the Cabinet Secretary, but I am accountable to the First Minister for my decisions and actions in leading the Welsh Government civil service and managing the organisation's resources.

366. In describing my responsibilities as Permanent Secretary, I should emphasise that, in contrast to central government departments which have one specific area of responsibility, the Welsh Government is responsible for a broad range of legislative, policy, and administrative functions and responsibilities. Despite this range of responsibilities, the Welsh Government is, and in my experience always has been, a compact administration. The Welsh Ministers and their senior officials are "under one roof" and are frequently in the same room together. This enables the organisation to take advantage of being able to work in a highly integrated way and to make decisions at pace. Cabinet papers and ministerial advice benefit from consolidated contributions from a range of policy officials and experts across the organisation, thereby enabling the Welsh Ministers' programme to be delivered in a co-ordinated way. This way of working, as well as the relatively small size of Wales, also means that we can work very closely with the wider Welsh public, private and third sectors, across the whole range of relationships and networks often in place.

367. As the Principal Accounting Officer, I am responsible for the overall organisation, management, and staffing of the Welsh Government, as well as its financial and other procedures. It is my responsibility to ensure that the organisation operates an effective and efficient system of internal control, including risk management, and that its effectiveness is regularly reviewed. In practice, this means that I am responsible for the regularity and propriety of relevant public finances, the keeping of proper accounts,

prudent and economical administration, the avoidance of waste and extravagance, and the efficient and effective use of all available resources.

368. I was preceded in this role by Dame Shan Morgan, who led the Welsh Government Civil Service from February 2017 to October 2021. I understand that Dame Morgan has also provided a statement to the Inquiry (ref. **M2B/WG/SM/01**).

The transition from Director General, HSS to Permanent Secretary

369. Clearly there was a significant change in my responsibilities as I moved across to this role from my Director General, HSS and NHS Wales Chief Executive roles. While there were key objectives I pursued, which reflected the First Minister's expectations for the Welsh Government Civil Service, as I took up the role we were once again experiencing growth in Covid cases arising from the Omicron variant. This growth led to visible action and response from the Welsh Government leading up to the Christmas period, using the 21 day review process and, as always, taking a cautious and protective approach to the Welsh population. My existing experience of the pandemic response was critical in exercising these further actions and, with the First Minister's agreement, I made the Omicron response the highest priority for the Welsh Government in those initial weeks, including by diverting resources and people onto Covid-19 response work, until cases were reducing once again.

370. I also benefitted from a two month transition period, from the date of my appointment to the date I took up post, which allowed me to gradually handover my Director General and Chief Executive responsibilities in a managed way, while working closely with Shan to step up into the Permanent Secretary role.

371. These roles continued during my transition to the Permanent Secretary role, and I consciously retained this team approach, setting our response during that phase in the context of other priorities and the objectives of the First Minister's Programme for Government.

372. As I was succeeded in my former role by a Director General, HSS and NHS Wales Chief Executive, Judith Paget, who was herself experienced in the system and the Covid-19 response, I was able to stand back from the specific intensity of the health

and care role, but used my knowledge and experience to good effect in steering the orgnaisation into the recovery phase against a backdrop of ongoing covid cases.

The First Minister and the Cabinet

373. In my Permanent Secretary role, my contact with the First Minister was enhanced and even more regular given our relationship and my role as his principal adviser. He was also interested in my leadership of the Welsh Government Civil Service. Our contacts were often daily, notably around broader office meetings, and occasionally through a day depending on matters.

374. My experience in the pandemic as Director General, HSS and NHS Wales Chief Executive was helpful in advising Ministers on, and leading, the Welsh Government's response to the Omicron wave in Autumn 2021 and into early 2022, not least as I was experienced in the established a routine for advice and decision-making, including the Cabinet's oversight and decisions at each 21 day review point.

375. Not all my contacts with the First Minister were about Covid-19 and the pandemic response, although as we moved into recovery mode, once the Omicron peak had passed, they remained a prominent backdrop to much of the Welsh Government's activity and we, of course, retained review cycles until 23 May 2022. There was other business for me to lead and advise on including resilience structures in our organisations, revised governance arrangements, supporting the development of sector recovery plans, and a restatement of, and focus on, implementing the Programme for Government. However, the First Minister would continue, in our regular contacts, to expect a view or updates on the Welsh Government's Covid-19 response and recovery, and of course I would respond to him when needed. While these informal contacts provided an important forum for sharing information and updating the First Minister, it is important to emphasise that decisions, including the Cabinet's decision to ease the final set of restrictions at the end of the pandemic, continued to be made on the basis of evidence, professional assessment, and through Cabinet-level decision making.

376. My role at Cabinet inevitably changed, too. As Permanent Secretary I was of course visible alongside the First Minister. My contributions were different, in that I supported the First Minister on the whole Cabinet agenda and contributed if requested; although,

I was no longer giving my own assessment in these meetings or on Ministerial calls. However, I needed to ensure that our Omicron response was clear to Ministers, and I oversaw the development of advice via other colleagues and teams. I used ExCo as the Welsh Government's oversight mechanism and for any decisions required, including in respect of capacity and resourcing issues. My changing role reflected changes across the Welsh Government, and the Cabinet's broadening agenda and increasing concern for other matters of government business.

377. I would also have supported the First Minister during the 21 day review meetings. However, others, notably my successor Judith Paget, would have stepped into my previous role and provided Cabinet with specific reports on NHS capacity and resilience.

378. I also continued to sit in on the routine informal briefings that were provided for the First Minister and the Minister for Health and Social Services, as this helped me to keep on top of intelligence and reflections.

379. While the majority of my contact with Ministers as Permanent Secretary tended to be through the Cabinet and more formal forums, upon my appointment I established more informal catch ups with Ministers as soon as I took up post, a practice which I have maintained since at routine (six-monthly) intervals. Typically, Ministers would approach me on broader issues unrelated to the pandemic response. I am also present, and visible, in Cathays Park at the beginning of the week and I share a floor with the First Minister and the Welsh Ministers, which always presents an opportunity for informal contacts, even though we retained social distancing measures and limits on office-working until the end of the pandemic. Throughout the pandemic, therefore, most contact with Ministers would still have been virtual rather than in-person.

380. It is also worth noting that I was already well known to Ministers prior to my appointment as Permanent Secretary, having been a director general in the Welsh Government since 2014 and particularly visible around the Cabinet and on Ministerial calls, due to my role in the Covid-19 pandemic response.

The Welsh Government Civil Service

381. The Welsh Government Civil Service's organisational structure largely mirrors the portfolios and policy responsibilities of the Welsh ministers. The Permanent Secretary leads the Permanent Secretary's Group, which included the Welsh treasury; finance; governance; digital; HR; and restart and recovery, when I took up post as the Permanent Secretary in November 2021. I produce here, as exhibit **M2B.WG.AG.01/049 – INQ000116521**, an organogram that shows the structure of the Welsh Government Civil Service when I took up post.

382. The Permanent Secretary also manages a team of directors general who, when I took up post in November 2021, were: -

382.1. Desmond Clifford, Director General, Office of the First Minister Group, who was responsible for: European transition, constitution and justice; international relations and trade; social partnership and fair work; the Welsh European Funding Office; the Cabinet Office; the cooperation agreement; strategic communications; legislative counsel and legal services.

382.2. Tracey Burke, Director General, Education and Public Services Group, who was responsible for: housing and regeneration; communities and tackling poverty; education, the Care Inspectorate Wales and the Healthcare Inspectorate Wales.

382.3. Andrew Slade, Director General, Economy, Skills and Natural Resources Group, who was responsible for business and regions; economic infrastructure; commercial and procurement; land, nature and food; environment and marine; climate change, energy and planning; culture, sport and tourism; skills, higher education and lifelong learning; finance and operations; and integration.

382.4. Judith Paget, my successor as Director General, Health and Social Services Group.

382.5. Reg Kilpatrick, Acting Director General, Covid Crisis Response and Director of the Emergency Coordination Centre Wales ("ECCW").

383. At the end of the pandemic, in April 2022, I put in place revised structures which I had developed with colleagues, and with the support of ministers, to provide more balanced support across the different ministerial portfolios. I produce here, as **Exhibit M2B.WG.AG.01/050 – INQ000116580**, an organogram which shows these revised structures.

The Board

384. As Permanent Secretary I reshaped and refocused the Board agenda to enhance its governance and assurance role, and to provide a more strategic role for the Board in helping us to look forward post-pandemic. While there is a clear distinction between the decision making roles of the Cabinet and the Executive Committee on the one hand, and the assurance role played by the Board on the other, I was keen to strengthen the Board's governance and assurance roles to enhance its oversight and to provide greater assurance to me as Permanent Secretary and Principal Accounting Officer.

385. As we emerged from the pandemic and focussed on recovery, rather than response, I also gave more visibility to the Welsh Ministers' Programme for Government, using the Board to drive this renewed focus on the implementation of the Welsh Ministers' priorities and objectives.

The Audit and Risk Assurance Committee

386. The Audit and Risk Assurance Committee supports the Board and accounting officer(s) on issues of risk management, control, governance, and assurance. It does not have a formal decision-making role but supports me to discharge my responsibilities as the Welsh Government's Principal Accounting Officer.

387. As the Welsh Government's Principal Accounting Officer, ARAC provides me with advice on a range of issues, including but not limited to the adequacy of the Welsh Government's procedures in respect of risk management and control, internal and external audit arrangements, compliance with statutory and regulatory requirements, the Welsh Government's accounts and annual reporting, and the adequacy of the Welsh Government's governance structures and processes.

388. Each Group within the Welsh Government also has its own ARAC; the Health and Social Services ARAC supported and assisted me in my role as Principal Accounting Officer for NHS Wales, and for the Health and Social Services Group. In turn, this enabled me to provide assurance to the then Permanent Secretary, Dame Shan Morgan.

389. I produce here, as exhibit **M2B.WG.AG.01/051 – INQ000350137**, the terms of reference for the Health and Social Services Audit and Risk Assurance Committee.

390. It is important to note that the Welsh Government's risk and assurance committees do not participate in either ministerial or executive decision making, although they do act as an important internal assurance mechanism.

391. As Permanent Secretary, the Audit and Risk Assurance Committee support me to scrutinise the operational aspects of the civil service and the Welsh Government as an organisation, for example in relation to capacity and resources. They also inform our contingency planning and preparedness for future events through their scrutiny of the Welsh Government's corporate risk register.

392. As Director General, HSS, the HSSG Audit and Risk Assurance Committee provided with me with assurance on key programmes like Test, Trace, Protect and the vaccination programme, and supported my oversight of the social care sector.

ExCo and ExCovid

393. As Permanent Secretary, ExCo now supports me in my role as Principal Policy Advisor to the First Minister, Principal Accounting Officer and Head of the Welsh Government Civil Service. I appoint officers to ExCo, and I chair ExCo meetings.

394. ExCo greatly assists me to discharge the responsibilities and accountabilities of my role, and it acts as the core decision-making body in respect of leading the organisation to deliver against the Welsh Ministers' objectives.

395. ExCo also plays a role in considering and filtering significant, cross-cutting, and high profile policy advice en route to Cabinet, and in the various review mechanisms that support delivery of the Programme for Government.

396. I did take a decision early on to strengthen ExCo's role in civil contingency planning, to raise its profile, to provide clear lines of assurance and accountability, and to ensure that lessons learned during the pandemic were captured, actioned, and embedded in our planning arrangements for the future.

397. In December 2021, shortly after taking up post as the Permanent Secretary, I took the decision to disband ExCovid and to draw ExCovid's functions back into ExCo. By this time, there was a clear cycle and routine associated with pandemic decision making in the Welsh Government. While we needed to respond to the Omicron variant, the processes and mechanisms through which we did this were by then well established and familiar. I felt confident that we could discharge the residual organisational decision making during the last phases of the pandemic without the need for the specific ExCovid mechanisms that had been established when pandemic preparation and response activity in the Welsh Government was most intense and most uncertain. I had also taken the decision to increase the frequency of ExCo meetings to weekly, and I felt confident that there was sufficient capacity to absorb the residual tasks undertaken by ExCovid.

Senior Leaders Group

398. Since taking up post as Permanent Secretary, I have taken the opportunity to build on this mechanism and use it to extend my leadership group to be more inclusive of directors across the organisation. The Senior Leaders Group now has a broader membership, and a more balanced agenda which includes the provision of significant updates and exchanges of key information, highlights key issues and risks for the organisation, engages with directors to provide support and take responsibility for implementing actions, and generally builds engagement across this important group.

399. There would have been some references to Covid-19 at these meetings between November 2021 and the end of the pandemic, as the pandemic continued to provide context for much of the Welsh Government's activity, but the Senior Leaders Group, like much of the Welsh Government infrastructure, was then focussed on recovery and delivering against the Programme for Government.

UK collaboration

400. By the time I took up post as Permanent Secretary in November 2021, the mechanism for liaison between the UK Government and the devolved governments had been put onto a more formal footing by the then Second Permanent Secretary at the Department of Housing, Levelling Up and Communities, Sue Gray, and was generally working very well. I found that communication with officials in the UK and devolved governments was generally open, supportive, and successful. I felt that this mature dialogue was important in discharging our responsibilities during the Omicron wave. It also filtered through into our engagement over non-Covid-19 related issues, such as the war in Ukraine.

The response and recovery phase: 1 November 2021 to 30 May 2022

401. By this time, there was a maturity in the Welsh Government's arrangements, and we had generally de-escalated many of the most stringent restrictions. We had also developed a well-established cycle of reviews and decision making, having undertaken many 21 day reviews by this point in the pandemic. The Cabinet, and the officials across the Welsh Government who supported them, were clear on their role in that process, and the steps that needed to be taken to prepare for, advise upon, and then implement the Cabinet's decisions at each 21 day decision point.

402. From a more personal perspective, I felt that I was able to bring significant insight to the experience of leading the organisations throughout this period as Permanent Secretary.

403. There was also a maturity in our interactions with the UK Government, and through the devolved administration liaison mechanisms, that created a culture of openness with significant information sharing, that supported our response to the emergence of the Omicron variant.

Public health and coronavirus legislation

404. I was not directly involved in the development of public health or coronavirus related legislation. This work was led, primarily, by Neil Surman, Deputy Director for Public Health, working in consultation with the Welsh Government's Legal Services

department. 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**.

Public gatherings

405. While I was aware of discussions taking place, and provided oversight over the advice provided to ministers on public gatherings, like the six nations rugby events, and the Stereophonics concerts in Cardiff, I was not personally involved in the preparation of that advice, which was based, I understand, on an analysis of the public health considerations, and the Welsh Government's legal powers to intervene.

Border controls and international travel

406. I was not directly involved in decisions in respect of international travel and border controls at any time during the pandemic.

PART C

Lessons Learned

407. I was part of many Welsh Government-wide lessons learnt processes that we drew into our review cycles and our executive arrangements. I oversaw lessons learnt on our planning and response internally within the HSSG; and I oversaw the health and care system pausing and reflecting on its own practice and actions. Irrespective of any post pandemic events, there was a healthy intention to always ask what could be done better and how could we improve. We also participated in internal and external review mechanisms that fed into the lessons learnt process, for example with internal audit, our risk committees and our external audit mechanisms, notably Audit Wales. Individual health organisations also shared their own internal lessons learnt processes.

408. Senedd committee reviews, in which we participated, notably the Public Accounts Committee and the Health Committee so far as my portfolio was concerned, provided valuable learning and feedback.

409. The TAG team were constantly reviewing evolving evidence and knowledge and feeding that into their advice and the Welsh Government's decision mechanisms. I would also say that our 21 day review process was naturally reflective and iterative and a way in which the latest understanding was presented to Ministers on an ongoing basis throughout the pandemic, and we were all learning lessons as the pandemic developed and our understanding of Covid-19 and the actions necessary to protect people from it developed over time.

410. However, I have explained, in my various corporate statements to the Inquiry, many of the formal lessons learned and the mechanisms through which the Welsh Government, the Health and Social Services Group, and the health and care systems in Wales learned lessons during and following the pandemic. I do not repeat that evidence here. Instead, I offer some more personal reflections on my experience of the pandemic.

411. I would also refer the Inquiry to the accountable officer letters that I wrote to the Permanent Secretary, Dame Shan Morgan, during my time leading the health and social care systems through the pandemic. They provide a valuable, contemporaneous record of my reflections at key moments during the pandemic. I produce these here as exhibits **M2B.WG.AG.01/052 – INQ000182427**, **M2B.WG.AG.01/053 – INQ000227296**, **M2B.WG.AG.01/054 – INQ000083233**, and **M2B.WG.AG.01/055 – INQ000083234**.

Listening

412. Ongoing dialogue with stakeholders was fundamental to shaping the context of the Welsh health and social care response to Covid-19 and associated pressures.

413. I always endeavoured to capture the tone of the system through my very regular contact with NHS leaders and ensure this was conveyed to ministers.

Collaboration

414. In response to Covid-19, the Health and Social Services Group, NHS Wales, social services and wider partner agencies took rapid action to ensure services and care continues to be provided against a backdrop of such extraordinary circumstances.

Despite the unique and challenging circumstances, I am proud to see the way in which the NHS and public services have responded and the manner in which we approached actions collectively.

415. I understand from colleagues that they sometimes found it difficult to achieve open communication with their counterparts in the UK Government, which I understand may have been in part driven by a lack of familiarity with some of the nuances of the Welsh devolution settlement and the conditions and needs that prevailed in Welsh communities.

416. I was not directly involved in most of these discussions as my role as Director General, HSS and NHS Wales Chief Executive during the majority of the pandemic had an inherently Welsh focus given my responsibilities to and for the NHS in Wales. However, one example that did cause some frustration in the early stages of the pandemic was the UK Government's apparent reluctance to recognise that our Chief Scientific Adviser for Health, Rob Orford, should play an active role in SAGE structures and discussions together with Peter Halligan, our Chief Scientific Adviser for Wales, so that Rob could translate the available evidence and analysis for the Welsh health context.

417. It seems to many of us in the Welsh Government that the devolved governments are best placed to identify who within our organisations should participate in certain UK groups and forums, such as SAGE, but there was a tendency for established civil service structures and hierarchies to dictate participants at a UK level. Unfortunately, this mapping across from the UK Government civil service to the devolved governments didn't always work in practice, or result in the best outcomes, because our structures and hierarchies were quite different.

418. For example, the Welsh Government has one Permanent Secretary who is responsible for managing the whole Welsh Government civil service and delivery of all the Welsh Ministers' devolved functions. Due to our compact size, we in the Welsh Government rely upon there being strength and depth at many levels in our organisation, and we tend to be more concerned with having the right person present, than we are with traditional civil service hierarchies.

419. In contrast, each department in Whitehall is led by a Permanent Secretary, and they have responsibility for the discharge of duties, powers, and functions within one

specific (albeit quite broad) policy portfolio. Consequently, when discussions were held Permanent Secretary to Permanent Secretary, the Permanent Secretary for, for example, the Department of Health and Social Care in England, who would be a real subject matter expert in their field, would be speaking to Permanent Secretaries in the devolved governments who were inevitably generalists, given their responsibility for delivery across all the government's devolved functions.

420. Similarly, the UK Government's initial suggestion that participation at SAGE should be restricted to Chief Scientific Advisors, failed to recognise that in a health-led crisis, the Chief Scientific Advisor for Health to the Welsh Ministers should participate in SAGE and its structures and discussions.

421. Due to the way in which civil contingency planning functions have been devolved, and the range of functions which have not been, we in the Welsh Government will always be reliant, to some extent, on the larger infrastructure at UK Government level and it will be important that we can continue to access the technical and expert support that we will need to supplement our national and local structures and meet the needs of our populations.

422. Going forward, I would wish to see the devolved governments given greater control over who participates in key forums at a UK level, while recognising that a balance needs to be struck between ensuring appropriate seniority, while also reflecting the needs of the devolved governments and the populations they serve. This will ensure that the best available evidence can be interpreted and contextualised for the Welsh context by the most appropriate expert, which will in turn improve the quality of advice that the Welsh Ministers can expect from their officials.

423. As decisions were made by ministers, and not by civil servants, I don't believe that it is my place to comment on the extent to which there was, or wasn't, divergence between the UK Government and the devolved governments, including the Welsh Government.

424. I would say, from my perspective, that I am confident that we in Wales did not diverge from our initial objectives to save lives and keep the people of Wales safe, or what we felt the best available evidence was telling us about the actions that needed to be taken to achieve this at any particular moment in time.

425. I would also say from my experience leading different parts of the Welsh public service infrastructure through the pandemic, that there is much that could be learned from the partnership approach that we have adopted in Wales, in terms of building trust and confidence, securing buy-in when difficult decisions need to be taken, and facilitating implementation and delivery at pace in a rapidly changing environment. It may be that closer cooperation, and indeed partnership, between the governments of the UK and their officials, could help us to better manage strategic risks around inconsistency, lack of clarity, and confusion that arose during the pandemic, particularly when the restrictions in place in one geographical area differed from those in place in an adjacent area.

Partnership

426. Our default approach in Wales is one of collaboration and I felt we discharged this routinely and at times beyond normal expectations during the pandemic. Once the routines had settled, ministers actively chose to draw on these collaborative arrangements across public services, local politics, emergency services and stakeholders, to draw partners into the team to make them aware of changes in real time, and increasingly, to influence and shape the decisions ministers would make.

427. I have given my own evidence on how accessible the NHS networks and organisations were to me and vice versa, but my own engagement went beyond just the NHS organisations themselves and extended to representatives of professional bodies and staff, by personal choice.

428. We have a one Welsh public service concept here in Wales – and what was strong pre-pandemic in terms of our natural ability to connect and work together evolved into something much stronger during the pandemic response.

429. One of the strengths of our response in Wales in overseeing the NHS pandemic response was the existing intimacy and structures that provided a collaborative base to the response. There were trusted relationships in place and clarity about our structures and oversight. However, we discharged these responsibilities in a compact team and relied on the NHS to support us with experience and expertise. At the same time, we gave cover for decisions and direction to the NHS to support more resilient responses across Wales.

430. Our close relationships in Wales reflects an intimacy across the whole system that extends beyond traditional functional boundaries and breaks down silos. I also think this has been an advantage throughout the pandemic, but our approach continues to work effectively with an increasing confidence about sharing choices, knowledge and expertise across sectors and stakeholders. We have reached out differently and, for me, that has landed different proposals and outcomes in Wales. As an example, the way in which the Test, trace, protect service was developed is evidence of this approach and is supported by some of the improved outcomes it achieved – with a localised delivery model, balancing local expertise across local government and the NHS, but with support and oversight nationally. It would also be true of the national vaccination rollout which, whilst led and overseen nationally, has absolutely relied on our local delivery structures in Wales and the reliance of our NHS and, where Wales was at times leading update and vaccination rates globally.

Subsidiarity

431. Throughout the Covid-19 pandemic, our health and social care systems faced the biggest challenge of our lifetimes. Colleagues across NHS Wales adapted to new ways of working to respond quickly to the need to continue to deliver essential services in a safe environment. NHS Wales was working closer than it ever had before and having to do new and innovative things that it had never done before. During a crisis, we look at issues differently and take instinctive action that challenges the status quo. As Chief Executive NHS Wales I saw many examples of innovative practice during the Covid-19 pandemic response, and it was essential to capture this and ensure we took the opportunity to learn the valuable lessons arising as a result.

432. Some of the changes brought in, especially around the digitalisation of NHS services, built on the foundations set out in 'A Healthier Wales'. The Welsh Government's and NHS Wales' collective response to Covid-19 accelerated the implementation of our long-term plan in many areas.

433. The Welsh Government, working with health, social care and other partners (including Audit Wales, the Bevan Commission, the Life Sciences Hub and the Wales Council for Voluntary Action) captured and evaluated innovative practices and new ways of working during the Covid-19 pandemic. The outcome was the NHS Wales Covid Innovation and Transformation Study (exhibit **M2B.WG.AG.01/056 - INQ000066469**).

This report was delivered through a 'Team Wales' approach, by a dedicated project commissioning group consisting of leads from Aneurin Bevan University Health Board, Health Education and Improvement Wales, the Welsh NHS Confederation and the Welsh Government. Leadership and resources were provided by the group's members, each of whom brought specific expertise and a bespoke organisational offer. This report and its underpinning research was prepared for the project commissioning group by an independent team of academics, researchers and practitioners from Swansea University School of Management (SoM), Swansea University Medical School (SUMS), the Accelerate HTC programme, the ARCH Health Board partnership, and the Bevan Commission. This collaboration demonstrates what is achievable in Wales as a small but highly networked nation with an integrated policy environment for health and social care.

Intimacy

434. The proximity of relationships across NHS organisations and partnership arrangements with social care and wider stakeholders assisted regular communications and collaborative decision making. I believe this was a major contributing factor to the effectiveness of the response across health and social care in Wales. This includes the direct contact I had with NHS chief executives and senior NHS representatives to inform and receive decisions; which meant that many of our central decisions were owned and had momentum as we looked to implement urgently in a highly pressured environment.

435. While the Health and Social Services Group and the wider Welsh Government is compact in size, rather than a constraint, I think this opens up a more open and collaborative leadership approach with the NHS in Wales, and more broadly with other agencies and stakeholders also – and we used that absolutely to our advantage during the pandemic response.

Evidence based decision making

436. The Technical Advisory Cell was central to the Welsh Government's response, under the leadership of Dr Rob Orford and Fliss Bennee. Key TAC products included regular surveillance and analysis of the pandemic through the Covid Situational Report, behavioural insights through Ipsos Mori surveys and focus groups, a Covid-19

evidence summary (the TAC brief), international monitoring, policy modelling projections, wastewater monitoring and modelling, forecasting and operational research. We also contributed, through TAC, at a UK level on UK alert levels and Joint Biosecurity Centre (JBC) pathfinder projects, co-authoring SAGE papers and coordinating four nations modelling, education science and awareness raising, all of which was used to help inform decision making across the full range of policy areas within the Welsh Government.

437. TAC also responded to direct commissions for scientific and technological advice from colleagues across the Welsh Government and ministers on the balancing of harms during the pandemic response, and on the reopening of society and businesses in Wales as we moved into recovery mode, as well in response to specific policy questions, which ranged from advice on weddings, ozone generators and face coverings; to more complex issues around the vaccine roll-out, key behavioural considerations for effective communications, effectiveness and impact of non-pharmaceutical interventions, and updates to the Coronavirus Control Plan indicators and thresholds.

438. The provision of advice on such a broad range of issues would not be possible without TAC's collaborative approach to science through its expert panel of Technical Advisory Group (TAG) members, which brought together behavioural and environmental science, socio-economics, policy modelling, data analysis and risk assessments for the purpose of providing advice that allowed ministers to balance different harms and take the right decisions at the right time for Wales.

439. I think TAC/TAG was an exemplar in our response and provided additional and diverse advice outside of the Chief Medical Officer for Wales and Health and Social Services Group advice structures.

440. Expert public health advice, from the Chief Medical Officer for Wales, Public Health Wales, and experts across Wales was a fundamental component of our response, underpinning all of the actions the Welsh Government took during the pandemic.

441. I also had the advantage of being able to access NHS operational data and to be able to inform ministers and colleagues on the NHS outlook and impact, daily, regularly and at Cabinet. I think some of the data modelling we undertook in Wales was exemplary

– operationally for the NHS, as well as tying into the 21 day cycle review process. We also harnessed the expertise in Swansea University, to help us to interpret and use this data in a meaningful way in our advice to ministers.

Transparency

442. I think we have communicated publicly in a very different and direct way with the population during the pandemic. During this most difficult period, there remained a very high level of trust and confidence in the Welsh Government, and the NHS throughout. There is certainly an opportunity as we emerge from the pandemic for government and public services to engage differently in citizen conversations.

443. My own guide has been to be factual, be clear on planning and response and to honestly respond to questions. I hope this was achieved and provided some reassurance on the scale of the NHS response and preparations as well as properly convey the pressures on the shoulders of our NHS and care staff.

Governance

444. We have seen change and actions at a pace, scale and urgency never delivered before. This period has represented unprecedented transformation which has been necessary to maintain services to the public, but for me also shows that urgent decisions can take place and be implemented consistently across Wales, with governance in place. It shows that the public sector can deliver fundamental change, at incredible pace, without relinquishing our commitment to good governance and good administration.

445. I would refer to the establishment of field hospitals (within days to weeks), the procurement of additional ventilators and personal protective equipment, the implementation of video consultations (within 3 to 4 weeks), and the vaccine roll-out (including the data systems that accompanied it), as clear examples of innovative decisions and actions that were taken at pace, but through the Welsh Government's existing governance structures and arrangements, which remained responsive, agile, and fit for purpose throughout the pandemic, despite external pressures and the rapidly changing environment in which we were all operating.

446. We also adapted our governance models at Cabinet levels, within the civil service and for the NHS itself. Rapid decision-making doesn't mean avoiding processes, structures or good governance principles – and I think we captured those in those different environments.

447. The use of the 21 day review cycle created a beat and template to underpin the regular decisions ministers needed to make – and with enough flexibility to expedite decisions within the cycles where needed.

448. I would also reflect that while the situation was incredibly fast moving, we were all working at a rapid pace, and the environment frequently felt frenetic, it never felt chaotic or out of control. I attribute, in large part, to the leadership that the First Minister and the Cabinet showed and to the fact that we continued to rely upon, and in fact leaned into, familiar governance structures and processes to manage the pandemic preparation, response, and recovery in Wales.

Informal communications

449. My routine practice was to use established governance and decision-making processes to ensure that decisions were made and recorded, reflected in ministerial advance, minutes, emails exchanges and correspondence. This occurred from the outset of the pandemic and throughout. I very rarely used WhatsApp (which was blocked on my Welsh Government mobile phone) and used text messages only on a limited basis to connect and communicate with Ministers, officials, special advisers, or my counterparts in the UK Government or devolved governments in relation to the pandemic response during the pandemic. There were clear formal decision-making mechanisms in place to support Ministers and officials to make decisions and informal communications were not used as an alternative or a substitute for these processes.

450. I did have some limited text message exchanges on my Welsh Government mobile phone from November 2021 onwards which I have shared with the Inquiry, although the majority of these exchanges did not concern the pandemic response. My Welsh Government mobile phone was replaced on the 11 October 2021 due to a malfunction which meant the battery was not charging properly and was unable to be used. For this reason I returned my mobile phone to the Welsh Government IT services and a new phone was issued on the 13 October 2021. I do not have access to the old phone

and no text messages were transferred to my new phone. I am therefore unable to disclose copies of text messages exchange prior to November 2021, although these would have been limited as described above and mostly did not concern the Welsh Government's pandemic response. I understand that when a phone is returned to IT service for security reasons the contacts, text messages, are not retained and the phone is 'wiped clean'. I am aware of the expectation to summarise and save to iShare any material which should be preserved as part of the Welsh Government's official records, but the texts were usually used to instigate contact or prompt responses by emails or calls and did not relate to matters for the official record as outlined in my description above of record-keeping.

451. I exchanged a small number of WhatsApp messages on my personal mobile phone, although these messages did not, in the main, concern the pandemic. Thes have been extracted from my personal mobile phone and disclosed to the Inquiry.

452. As a general point, once the functionality was available in the Welsh Government, my general practice was to use the Teams instant messaging facility as a communication mechanism internally. However, our corporate IT policy automatically deletes those exchanges after 30 days and they are not retained.

453. In respect of policy development and decision-making mechanisms within the Welsh Government, my practice was to direct these through, and to rely upon the appropriate internal mechanisms, including the preparation of Ministerial Advice and Cabinet papers, minutes and records of meetings, email exchanges, and correspondence internally and externally and these will all have been retained as part of the Welsh Government's corporate record.

Evidence before the Senedd

454. I produce here, as exhibit **M2B.WG.AG.01/057 – INQ000350666**, a chronology of my evidence before the Senedd and its committees during the pandemic, and as exhibits **M2B.WG.AG.01/058 – INQ000087990**, **M2B.WG.AG.01/059 – INQ000087993**, **M2B.WG.AG.01/060 – INQ000087994**, **M2B.WG.AG.01/061 – INQ000087996**, **M2B.WG.AG.01/062 – INQ000087997**, **M2B.WG.AG.01/063 – INQ000087998**, **M2B.WG.AG.01/064 – INQ000088000**, **M2B.WG.AG.01/065 – INQ000088003**, **M2B.WG.AG.01/066 – INQ000088004**, **M2B.WG.AG.01/067 – INQ000087999**,

M2B.WG.AG.01/068 – INQ000088005, **M2B.WG.AG.01/069 – INQ000088006**, **M2B.WG.AG.01/070 – INQ000350636**, **M2B.WG.AG.01/071 – INQ000350635**, the transcripts of my evidence.

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.

Signed: **Personal Data**

Dr Andrew Goodall

Dated: 8 January 2024