Witness Statement of: Andrew Goodall

No. of Statement: 4

Exhibits: 58

Date of Statement: 4 December 2023

UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF ANDREW GOODALL

I, ANDREW GOODALL, WILL SAY AS FOLLOWS:

1. I provide this statement in response to a request made by the Chair of the UK Covid-19 Public Inquiry ("the Inquiry") under Rule 9 of the Inquiry Rules 2006 dated 17 January 2023 and referenced M2B/NHSW/01.

Preface

2. The purpose of this statement is to assist the Inquiry in its understanding of the structure of the NHS in Wales and the roles and responsibilities of its constituent parts in sharing information to and advising the Welsh Government in response to the Covid-19 pandemic between January 2020 and 30 May 2022 ("the specified period").

3. This will be my fourth statement as part of Module 2B of the Inquiry. While the role of NHS Wales was briefly outlined in my statement referenced M2B/HSSG/01, I will in this statement provide more detail of the structures and role of NHS Wales and how its composite parts interacted with the Welsh Government and the Welsh Ministers, however, it is important to note that throughout such interaction was primarily through the Health and Social Services Group ("HSSG") headed by the combined office of the Director General Health and Social Services ("DG HSS") and the Chief Executive NHS Wales.

4. During the pandemic period covering January 2020 to November 2021 the position of DG HSS and Chief Executive NHS Wales was held by myself, and since November

2021 this position has been held by Judith Paget. I took up the role of DG HSS and Chief Executive NHS Wales in 2014, having prior to that been Chief Executive of Aneurin Bevan Local Health Board. During the pandemic period this prior experience and relationships in place from my role tenure from June 2014 was incredibly helpful. I will provide more detail on the role of the Chief Executive NHS Wales role in this statement but wish to highlight that I could not have performed the role during the pandemic without the support and tremendous hard work of those colleagues in NHS Wales, who when faced with what felt like an impossible situation, pulled together and delivered for the people of Wales. I am incredibly proud and grateful for the outstanding work, commitment and actions above and beyond normal responsibilities made by NHS Wales staff and organisations.

5. From the outset it is important to note that while the term "NHS Wales" is commonly used, unlike NHS England, there is no actual legal entity of this name. NHS Wales is used to collectively refer to Local Health Boards ("Health Boards"), NHS trusts and Special Health Authorities ("SHAs") (collectively "the NHS bodies") and those who they contract with to provide a range of primary, secondary, and specialist tertiary care services and community services including district nurses, health visitors, midwives, community-based speech therapists, physiotherapists and occupational therapists. A governance map of NHS Wales is exhibited at **AGMB2NHSW01/01-INQ000177485**.

6. When I refer to NHS Wales in this manner throughout this statement I am using the term to cover the collection of NHS bodies in Wales and those who interact with them. I will also refer to specific bodies who form part of NHS Wales and had a specific role or function during the pandemic.

7. In view of the available time since the rule 9 was issued and the broad scope of the request, the content of this statement is not based on a full examination of all the documents that are relevant to the work of the Government and NHS Wales over the pandemic period. Furthermore, I do not have access to documents held by the organisations who are collectively referred to as NHS Wales. Thus the information in this statement and the material exhibited may not provide a complete picture, rather this statement is produced to illustrate key aspects of the NHS Wales administration and the provision of advice and information to decision makers in Welsh Government.

8. In light of the above, in preparing this statement I have relied on advice and information from members of the Welsh Government's senior civil service team. Samia Edmonds, NHS Planning Director has provided information on the work of the Health and Social Services Covid-19 Planning Response Group which she chaired; Chris Jones, Deputy

Chief Medical Officer and National Clinical Director NHS Wales has provided information on wider organisation NHS Wales worked with and clinical input provided and finally Irfon Rees, Director of Health and Wellbeing has provided overall input.

Legislative background and structure of NHS Wales

9. My Director of Legal Services, Helen Lentle, has provided a detailed draft statement to the Inquiry which sets out the legislative history of devolution in Wales including the current statutory framework under the Government of Wales Act 2006 ("GoWA") (as amended) that constitutes the Welsh Government and provides the Welsh Ministers with their executive competence. I will not outline the legal background of the Welsh devolution settlement given that this has been covered fully elsewhere.

10. Health services are almost entirely devolved in Wales, which means the Welsh Ministers are ultimately responsible for NHS Wales, although this is not to say that the NHS bodies in Wales do not operate without any autonomy or independence. The Welsh Ministers set the high-level policy framework and targets for NHS Wales, but delivery of health services in Wales is by the Health Boards and Trusts in Wales.

11. The organisational and governmental structure of the NHS in Wales is primarily set out in the National Health Service (Wales) Act 2006 ("the 2006 Act"). The Act consolidated in relation to Wales the provisions of the National Health Service Act 1977 and associated legislation in order to set out in one statute the distinct structure of the Welsh NHS. In England, the National Health Service Act 2006 provides the legislative structure for the NHS in England. There are many differences between the structures and governance of the NHS in England and Wales, especially with regards to the health service bodies in operation in Wales. For example, there are three principal kinds of NHS bodies under the 2006 Act: Health Boards, Trusts and SHAs. In England however there are also NHS Foundation Trusts and Clinical Commissioning Groups among other bodies such as Public Health England and NHS England.

Local Health Boards in Wales

12. In Wales healthcare services are primarily delivered by Health Boards who have a role as both the commissioner and provider of services in their local area, with responsibility for the health of their local population. This includes primary, community, acute and mental health services.

13. There are currently seven Local Health Boards in Wales:

    a. Aneurin Bevan University Local Health Board (covering Newport, Torfaen, Monmouthshire, Caerphilly and Blaenau Gwent local authorities)

b. Betsi Cadwaladr University Local Health Board (covering Flintshire, Denbighshire, Gwynedd, Wrexham, Conwy and Anglesey local authorities)

c. Cardiff and Vale University Local Health Board (covering Cardiff and Vale of Glamorgan local authorities)

d. Cwm Taf Morgannwg University Local Health Board (covering Bridgend, Merthyr Tydfil and Rhondda Cynon Taf local authorities)

e. Hywel Dda University Local Health Board (covering Carmarthenshire, Pembrokeshire and Ceredigion local authorities)

f. Powys Teaching Local Health Board (covering Powys)

g. Swansea Bay University Local Health Board (covering Neath Port Talbot and Swansea local authorities)

14. The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 sets out the detailed requirements for the constitution and membership of Health Boards in Wales.

15. The members of a Health Board consist of a chair, vice-chair, officer members (representative of different healthcare professions and responsibilities), nine non-officer members (which must include a local authority member, a voluntary organisation member, a trade union member, and a person who holds a health-related post in a university), and any associate members. The chair, vice chair and non-officer members are appointed by the Welsh Ministers. The Welsh Ministers may also appoint up to three associate members, while the Health Board may appoint one associate member.

16. The Health Board appoints the officer members. The officer members consist of the following positions in the Health Board:

    a. a chief officer;

    b. a medical officer;

    c. a finance officer;

    d. a nurse officer;

    e. an officer who has responsibility for provision of the following—

        i. primary care services;

        ii. community health services; and

        iii. mental health services.

f. an officer who has responsibility for workforce and organisational development;

g. an officer who has responsibility for public health;

h. an officer who has responsibility for the strategic and operational planning of the provision of health services;

i. an officer who has responsibility for therapies and health science.

17. Exhibit **AGMB2NHSW01/02-INQ000182572** is a list of the Health Board chief officers and chairs for the specified period is set out.

18. All independent members may be appointed for a period of no longer than four years (other than associate members appointed by Health Boards, who may be appointed for a period of no longer than one year). Members may be reappointed at the expiry of a period of appointment but cannot hold office for more than eight years (four years in the case of associate members appointed by the Health Board).

19. The principal functions of Health Boards are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009 ("the Directed Functions Regulations"), which are effectively directions issued by the Welsh Ministers in exercise of their power under section 12 of the 2006 Act.

20. The Welsh Ministers delegated to Health Boards functions under the 2006 Act as well as under six other statutes, the details of which are set out in a schedule to the Directed Functions Regulations. These functions include the Welsh Ministers' general duty under section 1 of the 2006 Act to continue to promote a comprehensive health service in Wales. In addition to those functions delegated by the Welsh Ministers, parts 4 to 7 of the 2006 Act impose specific duties on Health Boards in relation to the provision of medical and dental services.

21. The Regulations made in 2009 were made as part of a wider reorganisation of the NHS in Wales. Prior to the changes, which came into force on 1 October 2009, there were 22 Health Boards in Wales, and the role of the Health Boards in Wales was effectively limited to the commissioning of health services, while the Welsh NHS Trusts had the function of providing 'front-line' medical services in Wales. However, the 2009 changes introduced an integrated healthcare system in Wales, under which Health Boards were effectively responsible for both commissioning medical services and for the provision of front-line medical services in Welsh hospitals.

22. During the pandemic period, Health Boards were under unprecedented pressure to perform these functions. I will detail further the role of Health Boards during the pandemic later in this statement.

NHS Trusts in Wales

23. As part of the reorganisation on 1 October 2009, seven NHS Trusts which previously delivered hospital services were dissolved with the exception of the Welsh Ambulance Service Trust ("WAST") and Velindre NHS Trust ("Velindre") which continued in existence.

24. Public Health Wales NHS Trust ("PHW") was established on the 1 October 2009 as a new NHS trust in Wales. The functions of PHW set out in statute are:

    a. Provide and manage public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;

    b. Develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;

    c. Undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and

    d. Provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.

25. PHW is the national public health agency in Wales. One of its roles is to protect the public from infection and to provide advice on epidemiology, and it played an important role throughout the pandemic in providing advice to the public, NHS Wales, and the Welsh Government. Further detail on the role of PHW is set out in the second part of this statement.

26. WAST is the national ambulance service for Wales. It was established pre-devolution on the 1 April 1998, with NHS Direct Wales becoming part of WAST in April 2007. WAST serves the whole population of Wales providing them with emergency services, unplanned critical care support and advice, as well as Non-Emergency Patient Transport Services ("NEPTS"). The service is divided into three regions with regional offices in Swansea and Cwmbran and the headquarters in St Asaph. WAST are also the host for the 111 service, which is an amalgamation of NHS Direct Wales and the front end call handling and clinical triage elements of the GP out-of-hours services and which operates across Wales.

27. Velindre was established on 1 April 1994 and at that time was a single speciality trust providing only cancer services. Over the years, the trust has significantly evolved and expanded. The main function of Velindre is to provide all-Wales and regional clinical health services to the NHS and the people of Wales. Velindre consists of two clinical divisions: Velindre Cancer Centre and the Welsh Blood Service. The latter works with its UK counterparts both formally and informally to ensure the safety of the blood supply chain.

28. Velindre also hosts NHS Wales Shared Services Partnership ("NWSSP") which I will detail further below.

29. Both WAST and Velindre's membership and procedures are contained in the NHS Trusts (Membership and Procedure) Regulations 1990. PHW has separate provision in the Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009. The members of NHS trusts in Wales consist of:

    a. A chair

    b. A vice-chair

    c. No more than six non-executive directors, excluding the chair and vice chair

    d. No more than six executive directors, which includes the roles of:

        i. The chief officer

        ii. The chief finance officer

30. In the case of Velindre, the executive directors must also include a medical or dental practitioner and a nurse or midwife.

31. In the case of PHW, the non-executive directors include:

    a. A person who holds a health-related post in a university

    b. A person with experience of local authorities in Wales

    c. A person who is an employee or member of a voluntary sector organisation with experience of such organisations in Wales.

32. The non-executive members are appointed by the Welsh Ministers. The chief officer is appointed by a committee of the chair, vice-chair and non-executive directors of the trust. In the case of the other executive directors, appointment is by the same committee with the addition of the chief officer. A list of the NHS trust chief officers is provided in exhibit **AGMB2NHSW01/02-INQ000182572**.

Special Health Authorities in Wales

33. There are two Welsh SHAs: Health Education and Improvement Wales ("HEIW") and Digital Health and Care Wales ("DHCW").

34. HEIW was established in 2018 and its functions relate to the planning, commissioning and delivery of education and training for the Welsh health workforce. This was the first Welsh SHA established by the Welsh Ministers.

35. HEIW consists of—

    a. a chair;

    b. not more than 6 other members who are not officers of HEIW in addition to the chair; and

    c. not more than 5 other members who are officers of HEIW, including the office of chief executive.

36. The chair of HEIW is appointed by the Welsh Ministers as are up to 6 other members in addition to the chair. The chief executive is appointed by the non-officer members and the other officer members by the chief executive and non-officer members together.

37. DHCW was established in 2020 and became operational in 2021. DHCW has such functions as the Welsh Ministers may direct in connection with the following areas:

    a. the provision, design, management, development and delivery of digital platforms, systems and services;

    b. the collection, analysis, use and dissemination of health service data;

    c. the provision of advice and guidance to the Welsh Ministers about improving digital platforms, systems and services;

    d. supporting bodies and persons identified in directions given by the Welsh Ministers to DHCW in relation to matters relevant to digital platforms, systems and services;

    e. any other matter so as to secure the provision or promotion of services under the 2006 Act.

38. The membership of DHCW consists of—

    a. a chair;

    b. a vice-chair;

    c. not more than 5 members who are not officers of DHCW in addition to the chair and vice-chair;

d. not more than 5 members who are officers of DHCW which must include:

    i. a chief officer;

    ii. a finance officer;

    iii. a clinical officer;

e. not more than 3 associate members.

39. The chair, vice-chair and up to 5 other non-officer members of DHCW are appointed by the Welsh Ministers. The chief officer is appointed by the non-officer members and all other officer members by the chief officer and non-officer members. Associate members are appointed by the Welsh Ministers or by DHCW with the Welsh Ministers consent. A list of the Welsh SHA chief officers is provided in exhibit **AGMB2NHSW01/02-INQ000182572.**

40. There are also two joint Special Health Authorities operating on an England and Wales basis: the NHS Business Services Authority ("NHSBSA") and NHS Blood and Transplant ("NHSBT").

41. The NHSBSA and NHSBT are established jointly by the Secretary of State and the Welsh Ministers. As these are joint SHAs the Welsh Ministers may direct the NHSBSA or NHSBT to exercise any of the functions of the Welsh Ministers relating to the health service in Wales which are specified directions made under the 2006 Act.

NHS Wales working together

42. NHS Wales is a close-knit network of organisations and a system well versed in working together collaboratively and with others outside of NHS Wales. The 2006 Act provides a number of legislative mechanisms to enable the NHS bodies to work together. Health Boards in particular have broad powers to make arrangements with any person or body to provide or assist in providing services under the Act; to exercise their functions jointly with a range of bodies included other Health Boards, Trusts, NHS Commissioning Board or Clinical Commissioning Groups and they may also be directed by the Welsh Ministers for their functions to be exercised by committees or by a SHA.

43. In addition to the three main types of statutory NHS bodies there are a range of committees, partnerships, associations and hosted bodies in place which also service and form part of NHS Wales. These organisations help to ensure an 'all-Wales' or "one-Wales" approach to much of what NHS Wales does and maximise opportunities for resource pooling and innovation. I have outlined these organisations below.

NHS Wales Shared Services Partnership ("NWSSP")

44. Velindre NHS Trust has the function of managing and providing shared services to the health service in Wales. NWSSP is the operational name for the Shared Services Committee of Velindre NHS Trust. NWSSP functions include functions directed by the Welsh Ministers such as payroll services, procurement services, and legal services for NHS bodies in Wales. The NHS bodies have also collectively agreed to transfer services to NWSSP such as health courier services, laundry services, and student award schemes. NWSSP delivers a wide range of high quality, professional, technical, and administrative services for and on behalf of NHS Wales also working with the wider public services, including Welsh Government. While I have referred to NWSSP sometimes this organisation is also sometimes referred to as "Shared Services".

Welsh Health Specialised Services Committee ("WHSSC")

45. The Welsh Ministers made Welsh Health Specialised Services Committee (Wales) Regulations 2009 so that the seven Local Health Boards in Wales work via a joint committee to exercise functions relating to the planning and securing of specialised and tertiary services. WHSSC is hosted by Cwm Taf Morgannwg University Local Health Board. The role of WHSSC is akin to that of NHS England in managing a budget for the commissioning of specialist services on a national level.

Emergency Ambulance Service Committee ("EASC")

46. EASC is a Joint Committee of all Health Boards in NHS Wales and is hosted by Cwm Taf Morgannwg University Health Board. The Minister for Health and Social Services appointed an Independent Chair through the public appointment process to lead the meetings and each Health Board is represented by their Chief Executive Officer; the Chief Ambulance Services Commissioner is also a member. The Joint Committee has been established to enable the seven Health Boards in NHS Wales to make joint decisions on the review, planning, procurement and performance monitoring of Emergency Ambulance Services ("EAS"), the Emergency Medical Retrieval and Transfer Service ("EMRTS Cymru") and the Non-Emergency Patient Transport Service ("NEPTS") and in accordance with their defined Delegated Functions. Although the Joint Committee acts on behalf of the seven Health Boards in discharging its functions, individual Health Boards remain responsible for their residents and are therefore accountable to citizens and other stakeholders for the provision of EAS, EMRTS and NEPTS. The arrangements effectively create a commissioner/provider relationship in which the seven Health Boards are collectively responsible for securing the provision of an effective emergency ambulance service for Wales. WAST, therefore, is

responsible for supplying the urgent and emergency medical services that the Health Boards require, based on a robust commissioning framework.

The National Collaborative Commissioning Unit ("NCCU")

47. The NCCU sits alongside EASC and is the collaborative commissioning service of NHS Wales. It is also hosted by Cwm Taf Morgannwg University Health Board. The NCCU is responsible for delivering national commissioning programmes for mental health and learning disability services, ensuring quality through collaborative commissioning.

Welsh Risk Pool Service ("WRPS")

48. The WRPS is a mutual organisation which provides indemnity to all Health Boards and NHS Trusts in Wales for clinical and non-clinical claims for negligence. The NHS Wales Risk Pool was established in 1996 when responsibility for meeting the cost of clinical negligence claims was transferred directly to NHS Wales. The WRPS arrangements are contained in various Welsh Health Circulars and Policy documents predating the pandemic.

NHS Delivery Unit ("NHSDU")

49. The NHSDU was formerly the Delivery and Support Unit and was established in 2005. The NHSDU is a non-statutory body hosted by Swansea Bay University Local Health Board. The purpose of the NHSDU is to provide the Welsh Government and the NHS with additional capacity and operational expertise and also provide expertise and advice to the Welsh Government on policy development matters, including the development of a wider suite of performance management and improvement tools and techniques. The NHSDU is accountable to the Director of Health and Social Services Group in the Welsh Government.

NHS Finance Delivery Unity ("FDU")

50. The creation of the Finance Delivery Unit was announced by the Cabinet Secretary for Health and Social Services in 2017. The purpose of the FDU is to enhance the capacity to monitor and manage financial risk in NHS Wales and to respond at pace where organisations are demonstrating evidence of potential financial failure; and accelerate the uptake across NHS Wales of best practice in financial management and technical and allocative efficiency. The Unit is accountable to the Director of Finance, Health and Social Services Group in the Welsh Government and the annual work programme is agreed and monitored through regular meetings with the Welsh Government. The Unit is hosted by Public Health Wales on behalf of the Health and Social Services Group.

NHS Wales Health Collaborative

51. The NHS Wales Health Collaborative is a national body, working on behalf of the Health Boards, trusts and special health authorities that make up NHS Wales. Through facilitating engagement, networking and collaboration between NHS Wales partners and other stakeholders, the Collaborative works to support the improvement of NHS Wales' services across organisational boundaries and improve the quality of care for patients. The Collaborative covers a broad range of clinical networks, national programmes and projects, major conditions implementation groups, and support functions. The Collaborative is hosted by Public Health Wales, on behalf of NHS Wales.

NHS Wales Informatics Service ("NWIS")

52. NWIS was a non-statutory organisation and part of Velindre NHS Trust. The Velindre National Health Service (Establishment) Order 1993 (as amended) sets out the Trust's functions given to them by the Welsh Ministers which includes: "to manage and provide to or in relation to the health service in Wales a range of information technology systems and associated support and consultancy services, desktop services, web development, telecommunications services, healthcare information services and services relating to prescribing and dispensing". NWIS delivered these services across NHS Wales as part of Velindre NHS Trust. NWIS functions were transferred to DHCW when it was established as a SHA and became operational in 2021.

NHS Wales Improvement Cymru

53. Improvement Cymru is the all-Wales Improvement service for NHS Wales. Its objective is to support the creation of the best quality health and care system for Wales so that everyone has access to safe, effective and efficient care in the right place and at the right time. It is part of PHW and is made up of experts in developing, embedding, and delivering system-wide improvements across health and social care. Improvement Cymru works closely with NHS Wales to support them to continually improve what they do and how they do it to help create a healthier Wales.

Welsh NHS Confederation

54. The NHS confederation is a membership organisation with funding contributions from all health organisations. The Welsh NHS Confederation is also part of the national UK wide NHS Confederation and host NHS Wales Employers. This organisation represents the seven Health Boards; three NHS trusts; Health Education and Improvement Wales; and Digital Health and Care Wales. While it is not part of Welsh Government's management structure for NHS Wales it is part of the NHS Wales

network and collaborative arrangements. The NHS Confederation acts as a driving force for positive change through strong representation, facilitating system leadership and our proactive policy, influencing, communications, events, and engagement work. The Welsh NHS Confederation is governed by a Management Committee. The Management Committee comprises the chairs and chief executives of the seven Health Boards, three NHS trusts, two SHAs in Wales and the director of the Welsh NHS Confederation.

Regional Partnership Boards

55. In addition to the NHS Wales bodies and organisations, Regional Partnership Boards ("RPBs") have been established to support the requirement for co-operation and partnership working between Health Boards and local authorities as part of the Social Services and Well-Being (Wales) Act 2014 ("the 2014 Act") to improve the well-being of the population and to improve how health and care services are delivered. The RPBs help to oversee and ensure integrated planning across health and social care by Health Boards and their local authority partners who are required under the 2014 Act to:

    a. produce regional population assessments.

    b. produce a regional area plan.

    c. provide a regional annual report.

    d. demonstrate citizen engagement and co-production.

56. There are 7 RPBs linked to the Health Board regional footprints:

    a. Cardiff & Vale Regional Partnership Board;

    b. Cwm Taf Morgannwg Regional Partnership Board;

    c. Gwent Regional Partnership Board;

    d. West Wales Regional Partnership Board;

    e. North Wales Regional Partnership Board;

    f. West Glamorgan Regional Partnership Board;

    g. Powys Regional Partnership Board.

Public Service Boards

57. NHS Wales is also required to work in co-operation and collaboration with other public bodies to improve the social, economic, environmental and cultural well-being of Wales. The Well-being of Future Generations (Wales) Act 2015 provides a legally binding common purpose – the 'seven well-being goals' – for public bodies in Wales

and places on specified public bodies, including Health Boards, a duty to act jointly via 'Public Services Boards' ("PSBs") to improve the well-being of their area by contributing to the achievement of the well-being goals. PSBs are established for each local authority area in Wales with the following statutory members of each PSB are:

a. Local authority
b. Health Board
c. Fire and rescue authority
d. Natural Resources Wales

58. In addition, the following are invited to participate:

a. Welsh Ministers
b. Chief constables
c. Police and crime commissioner
d. Relevant probation services
e. At least one body representing voluntary organisations

59. Each PBS must carry out a well-being assessment and publish an annual local well-being plan. The plan sets out how they will meet their responsibilities under the Well being of Future Generations (Wales) Act 2015.

Chief Executive NHS Wales

60. As previously outlined, the Director General of the Health and Social Services Group ("HSSG") holds a combined role as Director General and a role referred to as the "Chief Executive NHS Wales".

61. While the role of Chief Executive NHS Wales is not a statutory role it is a significant and distinctive post located in the Welsh Government, bringing together the responsibilities of a Director General in the Welsh Government with the leadership and oversight of NHS Wales.

62. The Chief Executive NHS Wales role involves the leadership and oversight of appropriate planning, delivery and assurance across NHS Wales, working with all NHS organisations. The Chief Executive NHS Wales provides leadership and support to the seven Chief Executives of the Health Boards, the three NHS Trust Chief Executives, two SHA Chief Executives and the Director of NWSSP. The role acts as the system leader for NHS Wales, overseeing those organisations responsible for more than 100,000 staff delivering NHS care and services across Wales.

63. A formal mechanism of providing this leadership role and bringing together the Director General role was via the NHS Wales Executive Board (later known as the NHS Wales Leadership Board). The purpose of this Board is to provide executive leadership, direction and oversight of the performance, delivery, quality and safety of NHS services, workforce and functions in Wales. As I have sought to outline in this statement, the NHS system in Wales operates as a collaborative, planned system in which outcomes will be maximised if organisations work together in a "one Wales" approach. The Board provides the leadership forum to support the "one Wales" approach to the oversight and delivery of NHS functions in Wales. The Board is attended by the Welsh Government's Health and Social Services Group Directors and the Health Boards, Trusts and SHA Chief Executives.

64. The Chief Executive NHS Wales is accountable to the Minister for Health and Social Services ("the MHSS") for the oversight and performance of NHS Wales, and responsible for providing policy advice and exercising strategic leadership and management of the NHS in Wales. As such, the role aligns closely with that of the DG HSS, as the senior civil servant in the HSSG. I held the role of DG HSS/Chief Executive NHS Wales from June 2014 until November 2021 when I started as Permanent Secretary and was succeeded as DG HSS by Judith Paget, who took up the role on a temporary basis pending a formal recruitment exercise.

65. This role is a unique one as a bridge between NHS Wales and Welsh Ministers. As I outlined in my earlier statement referenced M2B-HSSG-01, a particular (and, possibly, defining) feature of the Welsh public healthcare sector is that, consisting only of 12 bodies, it is intimate. During the pandemic we were able to use existing arrangements between the Welsh Government and NHS Wales for regular and effective two-way communication to identify and resolve problems quickly. This proximity of the healthcare system to government enabled speedy contact and discussion when needed, with organisations, stakeholders and professional representatives. This put us in a strong position in terms of existing relationships and mechanisms when the pandemic hit, and we have sought to learn from this, as I will outline further below.

Governance of NHS Wales

66. Each NHS body is responsible for ensuring appropriate governance arrangements are in place to maintain effective operation and delivery of health services to the people of Wales. The 2006 Act allows the Welsh Ministers to give directions and instructions to NHS Wales. In addition to statutory instruments, these directions and instructions can

take the form of:

a. Welsh Health Circulars ("WHC") – (these have previously also been referred to as Ministerial Letters) as a mechanism for the Minister to issue guidance to NHS bodies on a wide range of issues; and

b. Accountable Officer Letters – these are used to provide specific direction or advice on issues of accountability, regularity and propriety and annual accounting exercises.

67. NHS bodies have a legal duty to comply with any direction issued by Welsh Ministers. Instruction or guidance issued through a WHC also has the same legal standing as a direction and should be treated as mandatory.

68. The Welsh Government's Health and Social Services Group may also issue instructions and guidance to NHS bodies to support a key policy requirement, or provide good practice guidance on a particular aspect of business.

69. The Boards of NHS bodies provide internal governance. As outlined above NHS Boards in Wales are comprised of the following members:

a. The Chair – whose role is to manage and develop the Board.

b. The Chief Executive – whose role is to be the Accountable Officer and be the operational leader of the organisation.

c. Executive Directors – who have a dual role as Board members, and operational executive leads for their part of the organisation, and where applicable, Medical Directors, Nurse Directors and Directors of Therapies having specific roles that provide a clinical voice at the Board.

d. Independent Members – whose role is to provide independent thinking, objectivity, governance and expertise.

e. Associate Members – who attend Board meetings on an ex-officio basis but do not have voting rights.

70. All Board members share corporate responsibility for formulating strategy, ensuring accountability and shaping culture. They also have a shared responsibility for ensuring that the Board operates as effectively as possible.

NHS bodies in Wales must agree Standing Orders (SOs) that set out the arrangements within which the Board, its Committees, Advisory Groups and NHS staff make decisions and carry out their activities. The SOs also incorporate the Standing Financial Instructions (SFIs) and a scheme of decisions reserved to the Board and a

scheme of delegations to officers and others. NHS Bodies must operate with the overarching NHS governance and accountability framework which incorporates the SOs, the schedules of reservation and delegation of powers and SFIs with a range of other framework documents. The Welsh Ministers issue model SOs upon which NHS Wales base their own on. The model SOs are amended from time to time by the Welsh Ministers, the most recent in the pre-pandemic period being in 2019. Set out below is the suite of documents provided to NHS Wales:

WHC 201/027	**AGMB2NHSW01/03-INQ000182571**
Letter to Chairs of NHS bodies	**AGMB2NHSW01/04-INQ000182570**
Annex 1 – table of amendments	**AGMB2NHSW01/05-INQ000353466**
Model Standing Orders for Health Boards	**AGMB2NHSW01/06-INQ000353464**
Model Standing Orders for NHS Trusts	**AGMB2NHSW01/07-INQ000353468**
Model Standing Orders for WHSSC	**AGMB2NHSW01/08-INQ000353467**
Model Standing Orders for EASC	**AGMB2NHSW01/09-INQ000353462**
Glossary of Terms – Health Boards	**AGMB2NHSW01/10-INQ000353465**
Glossary of Terms – NHS Trusts	**AGMB2NHSW01/11-INQ000353470**

71. NHS bodies are also required to produce an annual, formal statement of assurance known as the Annual Governance Statement, signed by the Chief Executive on behalf of the organisation, and published as part of its annual accounts. The statement on internal control provides citizens and other stakeholders with a level of confidence on the way in which an organisation is led, the efficiency and effectiveness of its operations and ultimately, its ability to deliver its strategic vision, aims and objectives. Boards of NHS organisations are also required to publish a public Annual Quality Statement. This statement sets out clearly the achievements and challenges over the previous year, as well as the improvements the Board has agreed to make in the year ahead, to continuously improve the delivery of high quality and safe services.

72. In addition to Board level reports and statements, all organisations are required to participate in the annually agreed set of national clinical audits and outcome review programmes published by the Welsh Government as well as determine their own local priorities. This needs to be complemented with a broader framework of improvement activity, incorporating actions to improve following reviews undertaken by bodies such as Healthcare Inspectorate Wales. Boards should also consider what actions and learning need to be taken across the organisation from findings in one area.

73. All NHS organisations in Wales are required to have a Quality and Safety Committee to ensure sufficient focus and attention is given to such matters. This must be served

by its independent members and report directly to the Board. Audit, Inspection and Regulation Bodies play a key role in assessing the quality of services to ensure standards are met and resources are being used effectively. This includes bodies such as Healthcare Inspectorate Wales (HIW), Community Health Councils of Wales, Audit Wales and the Health and Safety Executive and in partnership with Care Inspectorate Wales (CIW) for social care.

NHS Wales funding and planning of services

74. NHS Wales is funded by the Welsh Government. In my statement reference M2B-WG-01 I outline how the Welsh Government is funded and therefore will not reiterate that here other than to note that the HSS Main Expenditure Group ("MEG") includes funding for NHS Wales. The Welsh Ministers are under statutory duties (contained in the 2006 Act) to fund NHS Wales.
75. NHS Wales therefore receives the majority of its funding from the Welsh Government to cover the day-to-day running costs of health services in Wales during each financial year. This takes the following forms:
    a. Revenue allocations to Health Boards to secure hospital, community and primary care services for their resident populations including GP's, General Dental Practitioners and Pharmacists;
    b. Capital allocations to Health Boards and NHS Trusts for operational and strategic capital developments; and
    c. Targeted funding for health improvement and other Welsh Government initiatives.
76. The Chief Executive NHS Wales is also designated by the Welsh Government's Permanent Secretary as the "Accounting Officer for NHS Wales", using powers in the Government of Wales Act 2006. The chief executives of the individual NHS bodies in Wales have a duty to their respective boards and, as the Accountable Officers for those organisations, to the Chief Executive NHS Wales as Additional Accounting Officer for NHS Wales. That relationship is governed by an Accountable Officer Memorandum issued by the Chief Executive NHS Wales. This Memorandum outlines the responsibility of the Accountable Officer in each NHS organisation for financial management/performance. The Memorandum sets out that the Accountable Officer is directly accountable, for all financial performance issues (and all other performance issues) delegated to the organisation, and to the Chief Executive NHS Wales as Additional Accounting Officer for Health and Social Services.

77. Health Boards and Trusts are also under a statutory financial duty to ensure they break even over a 3-year accounting period and under a duty to plan how they will deliver services to meet the needs of their local population. Each NHS body receives specific core funding allocations from the Welsh Ministers based primarily on the size and make-up of their local population, with powers to make additional payments if necessary and subject to directions by the Welsh Ministers.

78. Summarised Accounts of the Health Boards, NHS trusts and SHAs are prepared each year in compliance with the accounting principles and disclosure requirements of the Government Financial Reporting Manual (FReM) issued by HM Treasury as applied to the NHS in Wales.

79. In my capacity as Additional Accounting Officer, I would sign the NHS Wales combined Summarised Accounts of the Health Boards and NHS trusts and SHAs which were laid before the Senedd. The summarised accounts of Health Boards, NHS trusts and SHAs in Wales for the year ended 31 March 2020 are exhibited in **AGMB2NHSW01/12-INQ000182519.**

80. NHS Wales operates under the Welsh Government's NHS Wales Planning Framework which gives statutory guidance on developing three-year plans linked to an NHS body's allocated budget, known as Integrated Medium Term Plans ("IMTPs") setting out how the NHS body will deliver services to meet the needs of their local population. The Welsh Ministers approve the annual IMTPs for each Health Board and trust, and Health Boards and trust deliver agreed plans within their allocated budgets. Welsh Ministers report to the Senedd before the end of any three-year accounting period on the Health Board's and trust performance. While SHAs and the other various committees and organisations which form part of NHS Wales are not under the same statutory planning duty, following approval by their respective committees and Boards, IMTPs are also submitted by these NHS organisations on a voluntary basis providing plans in the spirit of the Framework.

81. An IMPT responds to Ministerial and governmental priorities and is one of the key enablers to achieving high-performing, timely, safe and sustainable services. IMTPs must demonstrate an integrated planning approach, which links to the population needs all set within the organisations longer term clinical services strategy. IMTPs must also align with 'Area Plans' developed with RPBs, Well-being plans developed by Public Service Boards and Mental Health Delivery Plans.

82. Following submission of an IMTP, based on recommendations from Welsh Government officials, Ministers will make a decision on whether or not to approve the

plan. If approved the Chief Executive NHS Wales will issue an accountability letter setting out any conditions for the year ahead. If the plan is not approved the NHS body will need to provide a detailed Annual Operating Plan to provide assurance and ensure smooth and sustainable provision of services to its population over the year ahead and appropriate monitoring and escalation arrangements will be put in place to oversee delivery.

83. While each NHS body produces its own IMTP or annual plan, in 2019 the first national IMPT for Wales was launched as part of one of the commitments in 'A Healthier Wales', which called for a "national plan for the NHS to be developed, bringing together all NHS Health Board and Trust IMTPs to produce a national picture". The National IMTP complements the NHS Planning Framework. This National IMTP provides a summary overview of the latest set of available IMTPs and annual plans submitted by NHS organisations.

84. During the pandemic period the individual IMTP process was paused and replaced with quarterly operational plans which I outline later in this statement. While the statutory IMTP process was recommenced once Covid-19 stabilised, a National IMTP has not yet been issued. The Welsh Government will look to re-establish this in time.

NHS Wales equality duties

85. The Equality Act 2010 and other Wales specific duties apply to public bodies including those statutory bodies which comprise NHS Wales. In Wales, the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 requires NHS Wales to consider how they can positively contribute to fairer society through advancing equality and good relations in their day-to-day activities and that the public sector equality duty is built into the design and delivery of services.

86. In 2011 Wales became the first country in the UK to incorporate children's rights into domestic law with the introduction of the Rights of Children and Young persons (Wales) Measure 2011. The Measure embeds consideration of the United Nations Convention on the Rights of the Child (UNCRC) and the optional protocols into Welsh law.

87. While the Measure imposes a "due regard" duty on the Welsh Ministers it does not directly impose any duties on public bodies, for example Health Boards and local authorities (through which many ministerial functions are discharged). More recent pieces of legislation, including the Social Services and Well-Being (Wales) Act 2014 and the Additional Learning Needs and Education Tribunal (Wales) Act 2018 have required Health Boards to have due regard to Part 1 of the UNCRC in specific circumstances. The process of having due regard can range from thinking about the

impact of decisions on children in the course of day-to-day work, to the formal application of a structured impact assessment tool accompanied by a record of the outcome.

88. The Additional Learning Needs and Education Tribunal (Wales) Act 2018 also requires Health Boards and local authorities to have regard to the United Nations Convention on the Rights of Persons with Disabilities.

89. On making allocations of funding to NHS Wales bodies and in issuing guidance and legislation the Welsh Ministers translate the statutory duties to the work of NHS bodies in Wales. Additionally, NHS bodies on receipt of allocation of funding are required in to ensure that they undertake integrated impact assessments for all major spending decision and have regard to the requirements of the Well-being of Future Generations (Wales) Act 2015 which sets out the seven 'well-being' goals in Wales, including a more equal Wales (i.e. the promotion of a society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances). Any changes in service provision are also required to be impact assessed to ensure the Welsh language is fully considered and any funding decisions must also take account of the population needs assessments for care and support needs that are produced as part of the requirements of the Social Services and Wellbeing (Wales) Act 2014.

90. NHS bodies IMTPs are required to demonstrate how the organisation proposes to meet the public sector equality duty and its arrangements for completing equality impact assessments.

91. The NHS Centre for Equality and Human Rights ("CEHR") provides central leadership on equality issues for NHS Wales and sits within the Quality, Nursing and Allied Health Professionals Directorate in PHW.

92. CEHR was established to support NHS Wales to build their own capacity and capability to:
    a. meet their statutory equality and human rights obligations
    b. demonstrate they meet the diverse needs of patients and staff when planning and delivering healthcare
    c. promote learning, collaborative working and best practice on equality and human rights across the NHS and wider Welsh public sector.

93. The Welsh Government, Welsh Local Government Association, and CEHR jointly developed the Equality Impact Assessment in Wales Practice Hub hosted by PHW

NHS Trust in 2015-16. This online resource provides information and support to public bodies in Wales to undertake Equality Impact Assessments ("EIAs").

94. In addition to the support by CEHR, all NHS bodies in Wales now have dedicated Equality and Diversity Officers. The all-Wales NHS Equality Leadership Group ("ELG") is an established network of Equality, Diversity and Inclusion Managers, Officers, Specialists and Leads from within NHS Wales's organisations whose aim is to provide an expert resource and advice on the promotion of Equality, Diversity and Inclusion (EDI) across NHS Wales through shared objectives, collaboration and facilitation.

95. During the pandemic, the ELG supported work on assessment of the impact of Covid-19 on Black, Asian and Minority Ethnic groups and made recommendations in April 2020 which sought to ensure NHS Wales organisations exercised their duty of care to staff in a precautionary way and to strengthen the risk assessment approach for staff from this cohort as well as from an intersectional perspective for all staff considering the known risk factors in addition to ethnicity included age, gender, body mass index and pre-existing conditions. This was important to ensure that all aspects of workforce decision making and planning during Covid-19 had equality considerations built in.

Planning for public health emergencies

96. Prior to 2020 there had been work across NHS Wales to plan, for a public health emergency, including pandemics. The Inquiry will in Module 1 have had detail of the pre-pandemic preparedness and role of NHS Wales. I will only touch upon this here to complete this introductory summary of NHS Wales's structures and role.

97. The LHBs, PHW and WAST are all category 1 responders for the purposes of the Civil Contingencies Act 2004 ("CCA 2004") and as such each of these NHS Bodies is separately required to comply with the CCA 2004, ensuring that emergency and business continuity arrangements are in place for which the respective Chief Executive Officers will be accountable. The Chief Executive Officer is expected to ensure that the Board receives regular emergency preparedness reports, at least annually, covering risk assessment, the resilience of emergency and business continuity plans against the risks identified, and the training and exercises undertaken to prepare staff and test response arrangements.

98. Additionally, the Chief Executive must ensure that an Executive Director of the Board is designated to take responsibility for emergency preparedness on behalf of the organisation, and an officer is appointed and adequately resourced to support the Executive Director and Chief Executive in the discharge of these duties. Each organisation has a designated emergency planning lead working full-time on NHS

resilience matters. In delivering their responsibilities under the Civil Contingencies Act 2004, NHS Wales contributes to multi-agency planning at all levels through their participation in the all-Wales planning structure and their engagement with Local Resilience Forums ("LRF"). As Chief Executive NHS Wales I was a member of the Joint Emergency Services Group ("JESG") and the Wales Resilience Forum ("WRF"). As a member of these groups my role was to represent the health bodies and provide a coordinating voice alongside WAST which is part of JESG and the WRF and PHW which is also part of the WRF, given these bodies' specialist areas.

99. NHS Wales also participates in the Wales NHS Emergency Planning Advisors Group (EPAG) with sub-groups being operated to address issues such as mass casualties, pre-hospital response requirements, health countermeasures and Wales NHS training and exercises, all feeding into the multi-agency planning arrangements at all levels. The NHS Wales Training and Exercise Group co-ordinates delivery of NHS Wales training and exercises in support of NHS emergency plans and to address national risks.

100. The unique challenges presented by the Covid-19 pandemic included its novel nature, the limited understanding of its medical science, its pattern of spread and its long duration. While many outbreaks and pandemics which occurred prior to Covid-19 did not present the same challenges, the Welsh Government was able to put in place measures and arrangements to respond to the types of pandemic it had planned for, and test these arrangements to such an extent that important lessons were learned and acted upon, which helped shape its response to Covid-19. As a result of the planning, testing and review of plans that was undertaken, Wales held in place a basis for the response which could be built upon and quickly adapted in response to the challenges the pandemic presented, and from which the more dynamic decisions and updated or new policies could be made as more scientific data emerged about the virus.

NHS Wales and the Covid-19 Pandemic

NHS Structure and Governance during the pandemic period

101. At the start of the pandemic NHS Wales was aware of the need to consider how it organises itself, what resources it has and what support from the Welsh Government it required to meet the forthcoming challenges.

102. NHS Wales wanted to ensure its response and actions were appropriate and in line with the scale of the concerns emerging from the modelling and evidence. The Reasonable Worst Case Scenario ("RWCS") in early March 2020 was that NHS Wales

capacity would be exceeded by a high degree with over half the population of Wales predicted to become symptomatic and a high number of those requiring hospital care, including ventilation and excess deaths resulting from serious infection. Coupled with this was the realisation that from an administration and governance perspective NHS Wales would, like other organisations, need to consider reorganisation to accommodate social distancing measures and account for the potential reduction in workforce due to illness or redeployment of staff.

103. To support initial actions by NHS Wales, I arranged a series of regular national Chief Executive telephone calls to share information and take on any strategic issues on behalf of the Chief Executives of the NHS bodies. These calls also aimed to demonstrate visible leadership of a co-ordinated response and a facility to support each other working as one NHS Wales. Similarly, from a clinical perspective, Frank Atherton, Chief Medical Officer ("CMO") ensured regular contact with Medical Directors and senior clinicians within NHS Wales. These telephone calls transitioned into virtual meetings as remote working became established during the pandemic. This was a positive move, facilitating higher quality engagement and enabled NHS leaders to maximise their available time and was less disruptive to the system yet still ensured we had a routine contact and a collective set of views.

104. Early March 2020 the all-Wales Board Secretaries met with Sioned Rees, Deputy Director, Mental Health, NHS Governance and Corporate Services, Welsh Government. NHS Wales was conscious that modelling indicated that the pandemic was expected to escalate over the coming weeks and months and therefore they needed to be clear on how to use NHS Wales governance arrangements to enable the continued appropriate functioning of NHS Wales but in such a way to ensure there was agile decision making and reduced bureaucracy given the expected demands on NHS Wales resources.

105. The Board Secretaries proposed a number of governance principles to use as framework against which to assess governance decisions during the early stages of the pandemic. These principles are detailed in exhibit **AGMB2NHSW01/13-INQ000182552** but in summary comprised of the following list of key principles to help focus NHS Wales's consideration of governance issues over the coming weeks:

a. Public interest and patient safety

b. Staff well-being and deployment

c. Good governance and risk management

d. Delegation and escalation

e. Departures

f. One Wales

g. Communication and transparency

106. The Board Secretaries proposed several changes to the way in which NHS Wales operated during this period including arrangements for Boards and their membership, decision making and schemes of delegation and end of year reporting. It also included a proposal to stand down the majority of NHS Wales committee and partnership committee meetings except for the Quality and Safety Committees and the Audit Committees.

107. Jo-Anne Daniels, Director of Mental Health, Vulnerable Groups and NHS Governance replied to the NHS Wales Board Secretaries on my behalf noting that all the proposals for streamlining the NHS Governance arrangements were broadly agreed and required no further action from the Welsh Government to facilitate them. This response is exhibited at **AGMB2NHSW01/14-INQ000182551**. The only exception was the request to amend the tenure of office for NHS Wales Board members and the requirement to hold an Annual General Meeting on a certain date.

108. On the first issue, as outlined above, each NHS Body has certain membership requirements set out in legislation. Many Health Boards and NHS Trusts needed to undertake recruitment of independent board members and non-executive members during the pandemic period. Legal requirements for Health Boards, PHW, HEIW, NWSSP, WHSSC and EASC limited the length of time or tenure of members appointed so if public appointments did not take place to replace members NHS Wales would be in breach of statutory requirements. It was recognised however that recruitment during the pandemic would be extremely challenging if not impossible to achieve. Based on the concerns raised by NHS Wales, the Welsh Ministers made the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These Regulations temporarily (up to the 31 March 2021) disapplied the legal limits on the length of time board members could be in office to minimise any disruption to the operation of NHS Wales and ensure continuity of service.

109. The second issue required changes to the model standing orders issued by the Welsh Ministers to provide some flexibility around the requirement to hold an Annual General Meeting. Updated model standing orders for use during the pandemic were issued in

July 2020 and a copy is exhibited to this statement, reference **AGMB2NHSW01/15-INQ000182591**.

110. The monitoring of NHS Wales performance by myself, as the Chief Executive NHS Wales, and by the Welsh Government changed during the pandemic period. The usual process of 3-year IMTPs was not realistic given the need for NHS Wales to respond quickly to what seemed like a constantly evolving picture. To ensure the planning principles and mechanisms for oversight were not lost, the Welsh Government initially asked Health Boards for weekly plans in the early phase of the pandemic. Once the position started to stabilise this changed to quarterly operational planning cycles which were introduced in May 2020 to provide assurance across the system.

111. Operational Planning Frameworks were issued for each quarter to set out the requirements for NHS Wales. These Frameworks took into account the modelling and RWCS coming from the Technical Advisory Cell and Technical Advisory Group to enable NHS Wales to plan in the short term with a particular focus on NHS capacity. The quarterly plans were aligned with the Ministerial priorities and focussed on the four harms:

    i. Harm from Covid-19 itself

    ii. Harm from an overwhelmed NHS and Social Care system

    iii. Harm from reduction in non-Covid-19 activity

    iv. Harm from wider societal actions/lockdowns

112. For the specified period the following frameworks were issued:

    a. NHS Wales Operating Framework - quarter 1, exhibit **AGMB2NHSW01/16-INQ000182468** refers. This Framework was to be read in conjunction with the following guidance in place at the time:

        i. The Welsh Government Framework for Recovery, exhibited in **AGMB2NHSW01/17-INQ000182406;**

        ii. Covid-19 Infection Prevention and Control Guidance to NHS Wales, as exhibited in **AGMB2NHSW01/18–INQ000352979;**

        iii. The Essential Services Framework, as exhibited in **AGMB2NHSW01/19–INQ000182443;**

        iv. The Hospital Discharge Service Requirements, as exhibited in **AGMB2NHSW01/20-INQ000227334.**

b. NHS Wales Operating Framework - quarter 2, exhibit **AGMB2NHSW01/21-INQ000182460** refers. This Framework was to be read in conjunction with the following:

    i. The World Health Organsation's Strength Adjusting Measures for Covid-19, as exhibited in **AGMB2NHSW01/22–INQ000353016;**

    ii. The NHS Covid-19 Secondary Care Pathway, as exhibited in **AGMB2NHSW01/23–INQ 000353351;**

    iii. The Faculty of Intensive Care Bridging guidance for Critical Care during restoration of NHS services, as exhibited in **AGMB2NHSW01/24–INQ000353463;**

    iv. The Wales Cancer Network update on Cancer Services, as exhibited in **AGMB2NHSW01/25–INQ000353461;**

    v. The Welsh Government's Rehabilitation: A Framework for Continuity and Recovery, as exhibited in **AGMB2NHSW01/26–INQ000282092;**

    vi. The Essential Services Guidance exhibited above.

    vii. The Royal College of Emergence Medicine guidance on infection prevention and control approaches in emergency departments, as exhibited in **AGMB2NHSW01/27-INQ000353469;**

c. NHS Wales Operating Framework – quarter 3 and 4, exhibit **AGMB2NHSW01/28-INQ000182474** refers. This Framework was to be read in conjunction with the Health and Care Standards Framework (2015) to guide decision making, as exhibited in **AGMB2NHSW01/29-INQ000353460.** It also included the following Annex documents set out below:

    i. Annexes A and B, which covered the detail of the aspects that must be covered in plans, as exhibited in **AGMB2NHSW01/30-INQ000353133**

    ii. Annex C, Maintaining Essential Services required during Non Covid 19 Pandemic as exhibited in **AGMB2NHSW01/31-INQ000353134**

    iii. Annex D, a planning minimum dataset, as exhibited in **AGMB2NHSW01/32-INQ000353135**

d. The Welsh Government Winter Protection Plan 2020-21, exhibit **AGMB2NHSW01/33-INQ000182498** refers. This was to be read in conjunction

with the Test Trace Protect strategy for Wales, as exhibited in **AGMB2NHSW01/34-INQ000182447.**

113. In December 2020 the Planning Framework 2021-22 was issued requiring organisations to develop an annual plan for 2021-22, as exhibited in **AGMB2NHSW01/35-INQ000353194**. The 2021-22 Framework built on the quarterly frameworks issued in 2020-21 and drew on the priorities set out in the Welsh Government's Winter Protection Plan. The IMTP Planning framework was brought back for the 2022-2025 period and the statutory process recommenced.

114. The quarterly plans submitted by NHS Wales during the pandemic demonstrated the sheer breadth of activity being pursued at pace across Wales. This included new ways of working, maintenance of essential services, new infection prevention and control measures, testing, workforce planning, all of which will be addressed in detail in later modules to the Inquiry, and the rapid construction of field hospitals, which I will touch upon later in this statement. I remain grateful to all those NHS Wales officials and staff who tirelessly worked to produce and deliver these plans for the people of Wales.

The role of NHS Wales in relation to the Welsh Government's decision making during the pandemic

115. The Welsh Government's response to Covid-19 was undoubtedly informed and improved by the views and expertise of those working in and across NHS Wales and culminated in the information and recommendations put to Ministers to inform decisions on the imposition and non-imposition of NPIs.

Key individuals in NHS Wales

116. Given my dual role at the time, as DG HSS and Chief Executive NHS Wales it made sense to bring NHS Wales more closely within the Welsh Government structures. At the start of the pandemic NHS officials, Gillian Richardson, Samia Edmonds and Andrew Sallows, were already working within the Welsh Government and were quickly deployed to Covid-19 workstreams. Early in the pandemic, I brought in Alex Howells to act as an interim Deputy Chief Executive for NHS Wales. Alex was also the Chief Executive of HEIW, a role she also continued in, while providing myself and the Welsh Government a reference point and experience. In this role Alex acted as a bridge to the service on a range of operational and risk areas, including the NHS Wales Operating Framework for Recovery.

117. A hybrid model of working was also achieved in part via the Covid-19 Planning and Response Group ("Covid-19 Planning and Response Group"). As I have outlined in my

statement referenced M2B-HSSG-01, this group was established by myself and the CMO to provide a forum for information exchanges and discussion around system risks.

118. The first meeting of the Covid-19 Planning and Response Group was held on 20 February 2020 and the group remained active throughout the whole of the specified period and remains active today with a wider focus on system resilience. Membership of the group was split between Welsh Government officials and NHS Wales officials (also including those from the partnership committees WHSSC and NWSSP) and initially included Health Inspectorate Wales and social care colleagues.

119. There were several sub-groups of the Covid-19 Planning and Response Group established to co-ordinate action and manage systems' risks across a number of areas. Similarly, these ensured a collaborative approach across the Welsh Government and NHS Wales. I have provided detail of the work of each sub-group in my statement referenced M2B-HSSG-01 so here I have limited myself to the roles of the HSSG and NHS Wales officials in co-chairing sub-groups:

   a. Primary & Community Care

   This group co-ordinated the planning and response across primary and community care and provided a point of contact for communications with the sector. The Co-Chairs of this group were Dr Liam Taylor, Professional Medical Advisor, Primary Care, Anuerin Bevan University Health Board and NR NR Nursing Officer, Primary and Community Care, Integration and Innovation, Welsh Government.

   b. Acute Secondary Care

   This group focused on freeing up hospital capacity and supported NHS Wales in its preparations across a number of patient pathways including those considering care for patients at home or in the community and hospital admission. Co-Chairs of this group were Dr Chris Jones, Deputy Chief Medical Officer, Andrew Sallows, Delivery Programme Director and Steve Curry, Chief Operating Officer, Cardiff and Vale University Health Board.

   c. Workforce Deployment and Well-being

   This group considered workforce modelling and well-being and also supported the Primary and Community Care group in relation to out of hours service planning. Co-chairs of this group were Helen Arthur, Interim Director, workforce

and organisational development, the Welsh Government and Julie Rogers, Deputy Chief Executive/Director of Workforce & OD, HEIW.

d. Digital Services

This group worked collaboratively across all the sub-groups sharing knowledge and information and recommending digital solutions and innovation. Co-chairs of this group were Ifan Evans, Director, Technology, Digital and Transformation and Helen Thomas, Interim Chief Executive Officer, NHS Wales Informatics Service.

e. Health Countermeasures

This group was chaired by David Goulding, Health Emergency Planning Adviser, and provided a link into the UK Countermeasures Network with a focus on supplies and access to essential supplies and PPE. The core members from PHW, NWSSP, the Social Services Integration Directorate (SSID) and the Health Emergency Planning Unit (HEPU). NHS Finance Delivery Unit's staff were later added to the Group, along with military liaison.

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

Recovery planning and re-establishing non-covid-19 services was a priority and this groups remit was to advise and assist in returning essential services as soon, and as safely, as possible. This Group was co-chaired by NR Deputy Director, Welsh Government's Cwm Taf Morgannwg University Health Board Intervention Team and Mark Dickinson, Director, Clinical Networks, NHS Wales Health Collaborative.

120. With NHS Wales officials deliberately in co-chair roles alongside the Welsh Government officials, this ensured that these sub-groups ensured a high standard of collaboration and information exchange from government to the system and back. This experience of working closing with NHS Wales was extremely positive and was maintained through the different phases of the pandemic response and helped to inform plans on how we work post-covid-19.

121. This model of working has particularly influenced the decision made to establish a new NHS Executive as a hybrid model, rather than a standalone organisation. It was recommended in the Parliamentary Review of Health and Social Care in Wales, January 2018 , reflecting on the earlier OECD Review of Health Care Quality 2016 , that the national executive function in NHS Wales be strengthened to develop a more strategic and coordinated set of incentives for Health Boards with a clearer distinction

between on the one hand, the national executive function strategically developing and managing the NHS, and on the other the national civil service function to support delivery of the NHS and Social Care priorities as set by the Welsh Ministers. The Welsh Government's Response – A Healthier Wales: Our Plan for Health and Social Care outlined plans for an NHS Executive function. Work on the NHS Executive was paused in 2020 to ensure that the resources of all organisations could be focused on other urgent and significant matters. Firstly, preparation for EU exit, followed by the need to focus efforts on the Covid-19 response.

122. Reflecting on the positive working relationship with NHS Wales, Welsh Ministers have decided on a hybrid model for the NHS executive, comprising of a small, strengthened senior team within Welsh Government, bolstered and complemented by the bringing together of existing expertise and capacity from national bodies in the NHS from the 1 April 2023, including:

    i. NHS Wales Health Collaborative
    ii. NHS Wales Finance Delivery Unit
    iii. NHS Wales Delivery Unit
    iv. NHS Wales Improvement Cymru

123. All NHS organisations are already directly accountable to Ministers, and the Welsh Government and will continue to be. Ministers will also continue to set priorities, targets, and outcome measures for the NHS. However, the NHS Executive will provide additional capacity at a national level to oversee and support delivery of these priorities.

124. During the pandemic NHS Wales saw other changes to its ways of working and structures with the introduction from the 26 March 2020 of Military Liaison Officers to each of the seven Health Boards, as well as WAST and Velindre. This Military support to the Planning and Response Cell continued until July 2021 when it was formally stood down although informal liaison and contact remains in place. A Military Aid to Civil Authorities ("MACA") request was submitted by WAST and approved to provide significant military personnel capacity until the end of March 2022.The Military Liaison Offices 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 during the most challenging of times.

125. It is also important to recognise the number of NHS Wales clinical staff who gave up their time to assist in the Technical Advisory Group ("TAG"), working with Rob Orford, the Chief Scientific Adviser for Health and with Frank Atherton, CMO.

126. TAG was established with significant support from three PHW experts, Dr Chris Williams, Dr Giri Shankar and Andrew Jones. A full list of TAG member is provided at exhibit **AGMB2NHSW01/36-INQ000182464**. These members of NHS Wales worked without any additional renumeration and provided essential expert advice and clinical input which informed the advice of the internal Technical Advisory Cell ("TAC") which was presented to Ministers.

127. At a local level there would also have been changes to ways of working and structures but these would not have been decisions needing discussion with myself in my Chief Executive NHS Wales role.

Role of the Chief Executive NHS Wales during the pandemic

128. The proximity of relationships across NHS Wales and partnership arrangements with social care and wider stakeholders assisted regular communications and collaborative decision making. As Chief Executive NHS Wales, I maintained regular contact with NHS Wales Executives and senior NHS representatives to inform and receive decisions. While most issues were raised via the regular NHS Executive calls I held, 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 already outlined above in the letter from the Board Secretaries Group as set out in exhibit **AGMB2NHSW01/13-INQ000182552**. Another example of this is set out in exhibit **AGMB2NHSW01/37-INQ000182388** in 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.

129. I do not recall any conflicts of opinion or serious objections, but I was always conscious of the reality that we had different organisations and experiences around the table and that we took advantage of the open conversation to capture thinking and actions. There was a spirit of open discussion in these meetings. I welcomed challenge and a frank discussion. Most discussions were able to lead to a shared and consensus view, despite a wish to ensure that a diversity of view and experience was reflected. It was important to have a shared assessment and ensure that decision took place with the urgency required. What might have worked for one Health Board area would not necessarily work for another and given the pace of things it was important to share innovation and highlight challenges being faced. This approach enabled the NHS

Wales to “own” many of the central decisions and ensured momentum to implement urgently. This was, in my opinion, a strong characteristic of the Welsh response.

130. The Minister for Health and Social Services (“MHSS”) joined meetings with the NHS Chief Executives and Chairs during this period on an ad hoc basis. Attendance at these meetings were to provide thanks to or garner views from NHS Wales and respond to any concerns raised. Notes of the meetings with the Chief Executives were taken from the end of March 2020 onwards with the assistance of the NHS Confederation who provided secretariate support, although the meetings were hosted and chaired by the Welsh Government. The minutes of these meetings have been provided to the Inquiry, including any attended by the Minister for Health and Social Services. I, and later Judith Paget, in the role of Chief Executive NHS Wales however represented the collective “voice” of NHS Wales in discussions with Welsh Ministers and the Welsh Government.

131. As part of my role, I would make assessments presented verbally at Cabinet meetings to support ministers in their decision making which included the balancing of concerns for NHS Wales resilience with ensuring actions were proportionate. I would also send NHS updates by email summarising the key facts and figures that I had received and what that meant for the NHS, an example of such an update is exhibited in **AGMB2NHSW01/38-INQ000353199.** I hope these assessments were received factually using the available data from across the NHS and care system but also appropriately conveyed the tone of NHS Wales. This was important to me, and I endeavoured to capture this tone though my regular contact with NHS Wales leaders and ensure this was conveyed to ministers.

132. This model of working was replicated through the NHS Wales and HSSG structures below the Chief Executive level. NHS officials and Welsh Government officials worked collaboratively to identify solutions, assess risk and build resilience and capacity in the NHS, with the Welsh Government officials providing information and advice to Ministers on these key areas. Equally however it is important to recognise that NHS Wales had a broad range of powers, and each body could act autonomously. To that end, there were also a number of local decisions and actions taken without involvement or support from the Welsh Government or sign off from the Chief Executive NHS Wales.

133. I do not recall any instances where Welsh Ministers or Welsh Government officials rejected advice from NHS Wales. However, the breadth and impact of the pandemic was wider than the NHS in Wales and decisions by ministers needed to balance the NHS assessment against the other consequences of covid-19 measures, such as

lockdowns and NPIs. This need for balanced decision making was recognised in 'Leading Wales out of the coronavirus pandemic', which outlined the wider principles to evaluate changes to the restrictions in Wales which included among other things consideration of the social, psychological and economical impact of measures as well as the balance of covid-19 related harms. This is exhibited above as **AGMB2NHSW01/17-INQ000182406.** The system was always supportive of actions and protective measures where this would mitigate demand of pressures on the NHS and would have supported these if they had happened earlier at times –but the Ministers' role was to balance the NHS assessment against all the other consequences of measures to respond to Covid-19. In order to do so Ministers and the Welsh Government were always trying to understand not just the actual position on the day, but also the likely demand and position over the forthcoming days or weeks. The information from NHS Wales and the assessment of its capacity was only one part, albeit it an important part, of a wider range of considerations which included technical advice from TAG/TAC and assessment of the wider Covid-19 related harms which considered the social, educational, psychological and economic impacts on the people of Wales.

134. Engagement between the Welsh Government and NHS Wales overall was positive and checked and refined continuously. In terms of on the ground information we trusted what NHS bodies were saying about the situation and trusted the local decisions that were being made. The Welsh Government and myself, as Chief Executive NHS Wales, set out the high level strategic objectives but we relied on Health Boards and Trusts to plan delivery and to seek out support or guidance if needed. In this respect NHS bodies were able to operate with a high level of autonomy within a clear framework.

NHS Wales role in assessing the equality impact of decisions by the Welsh Government

135. Throughout this period decision making by NHS Wales and Welsh Ministers continued to be assessed against their statutory duties. As outlined above the Welsh Ministers and NHS Wales were required to undertake an equality impact assessment ("EIA") as part of their duties under the Equality Act 2010. Each NHS body would have been undertaking these assessments at a local level in respect of local decisions and hold that information as part of their individual organisation's records.

136. In respect of decisions taken by Welsh Government, due to the urgency of the situation and exponential increases in Covid-19 transmission decisions at the start of the Covid-19 pandemic were often made without a formal assessment of the impact on vulnerable people. However, issues of equality and vulnerability were part of the consideration of

some of our early actions and part of the balancing of covid-19 related harms as outlined above and set out in 'Leading Wales out of the coronavirus pandemic'. For example, in the introduction of measures for the shielding of vulnerable individuals in March 2020 and the measures introduced in collaboration with NHS Wales employers and the Association of Directors of Social Services ("ADSS") to protect the ethnic minority health and social care workforce in in May 2020, which were representative of health protection actions for a community, given the evidence at the time. In making decisions the Welsh Government would seek to engage with CEHR and the All-Wales NHS Equality Leadership Group, as well as others where possible to ensure consideration of equality issues as part of the process despite the absence of a formal EIA. Welsh Government officials would on occasion be invited to attend meetings of the NHS Equality Leadership Group. As outlined above, early in the pandemic the Equality Leadership Group considered the disproportionate effect that Covid-19 infections was having on health and care professionals from Black, Asian and Minority Ethnic backgrounds. Recommendations from this Group are exhibited in **AGMB2NHSW01/39-INQ000353340** and these resulted in the development of the All Wales Covid-19 Risk Assessment Tool issued by the Welsh Government in September 2020. Members from NHS Wales also formed part of the Black, Asian and Minority Ethnic Covid-19 Advisory Group and socio-economic subgroup.

137. Additionally, particularly in respect of the Covid-19 Restrictions in Wales, PHW provided a wealth of data via their Public Engagement Survey which they started conducting around April 2020. Each week, PHW would conduct interviews with people across Wales, to understand how Covid-19 and the measures being used to prevent its spread were affecting the physical, mental and social wellbeing of people in Wales. The outcome of this survey would be provided to the Welsh Government's Knowledge and Analytical Services team and provided an important insight into the impact of the Welsh Government's response to Covid-19.

138. In August 2020, the Senedd's Equality, Local Government and Communities Committee published a report entitled, 'Into sharp relief: inequality and the pandemic", as exhibited in **AGMB2NHSW01/40-INQ000353436** which recommended that the Welsh Government should ensure that each major policy or legislative decision during the pandemic should be accompanied by an effective equality impact assessment, and an analysis of the impact on human rights. This recommendation was made following a consultation process in which the Equalities and Human Rights Commissioned raised concerns over publication of equality impact assessments. The Committee noted that while decisions at the start of the pandemic needed to be made at quickly,

reducing inequality must be a priority for Wales's recovery and called on the Welsh Government to set an example to the rest of the public sector and ensure that the decisions it makes are fully impact assessed. The Welsh Government's Black, Asian and Minority Ethnic (BAME) Advisory Group recommendations also emphasise the importance of systematic, published equality impact assessments. The Welsh Government accepted the recommendation, and since that time published dozens of impact assessments related to the Covid-19 pandemic on its website. These EIA's include the findings from PHW's Public Engagement Survey. A list of all published EIAs is provided in exhibit **AGMB2NHSW01/41- INQ000227405**, copies of which have been provided to the Inquiry.

Distinct functions and responsibilities of NHS Wales during the pandemic

139. This statement is made as part of Module 2B which examines the decision-making of key groups and individuals within the government in Wales however in outlining the wider role of NHS Wales, I cannot omit reference to the mammoth task undertaken to ensure delivery of health care services during this time. The distinct functions and responsibilities of NHS Wales during the pandemic will be subject to detailed review in subsequent modules so here I have limited myself to a few standout examples.

140. PHW had a predominant role in the Covid-19 response Wales. In the early stages PHW visibly and professionally stepped up acting in a major incident mode for its own functions providing expert health protection leadership and co-ordination at a national level. PHW. They had a particular role in the testing programme for Wales. The scale of testing and its profile meant that initially the Welsh Government had less central resources to support this and was particularly reliant on advice and support from internal professional advisors and PHW, on behalf of NHS Wales. The Welsh Government had initially assumed that the operational side of delivery would be handled by NHS Wales but it became clear that this was not possible. Following advice from Military planners a Testing Cell was established under Jo-Anne Daniels, Director Covid-19 Testing for Welsh Government, which co-ordinated activity across the Welsh Government but with PHW continuing to work with Health Boards to establish the Community Testing Teams and Units.

141. Test, Trace and Protect ("TTP") was a crucial part of the Welsh Government's approach to limiting the spread of Covid-19 and reducing the need for restrictions on people's lives. The TTP programme was developed rapidly from scratch through the partnership arrangements with NHS Wales and local authorities which were put in place when the pandemic first hit in March 2020. TTP system in Wales had national

oversight from the Welsh Government but was heavily reliant on the technical expertise and experience that sits within PHW, Health Boards, local authorities, third sector and NWIS. Before the launch of TTP, pilots were run in Hywel Dda, Powys, Betsi Cadwaladr and Cwm Taf Morgannwg Health Board areas with each pilot designed and delivered by local authorities working in partnerships with Health Boards. This was a useful opportunity to test systems and processes in different parts of Wales and enabled PHW, Health Boards and local authorities to have ownership of the process, and the ability to use local intelligence and knowledge to shape responses to the pandemic. The TTP programme saw different parts of the Welsh public and third sector work together well, in strong and effective partnerships, to rapidly build a programme of activities that is making an important contribution to the management of Covid-19 in Wales.

142. The vaccine programme in Wales is another example of distinct functions and responsibilities during the pandemic. This will be explored in further modules by the Inquiry but each Health Board and trust were integral parts of the All Wales Covid-19 Vaccination Programme and worked incredibly hard to deliver the outstanding vaccination results seen in Wales.

143. NWSSP worked closely with the Welsh Government throughout the pandemic to ensure the supply of PPE to NHS Wales as well as primary care providers, social care, nursing homes, domiciliary services, hospices and independent hospitals. Despite the Welsh Government establishing a dedicated PPE Supplies Cell to oversee procurement of PPE, NWSSP played a significant role by taking on the broader responsibilities for procurement and logistics and they deserve much credit for the fact that Wales did not run out of PPE and in fact were in a position to offer mutual PPE support to other UK home nations during the early stages of the pandemic.

144. Led by the Nosocomial Transmission Group that was established by Welsh Government, a Welsh Government Covid-19 outbreak reporting system was co-produced with NHS Wales. This allowed for timely assessment of Covid-19 outbreaks in Health Boards and Velindre and provided assurance that appropriate measures were being taken to mitigate transmission to patients and staff.

145. Additionally, as the pandemic period progressed through it's various phases NHS Wales played a key role in recovery planning and the restoration of activity across the health service in Wales. While this was in part captured, at a formal level, in the operating frameworks issued, NHS Wales organisations were continually testing the ability of the system to do more "routine" activities and restore clinical activity while

working within the extant restrictions and public health situation. This work was overseen by the Essential Services sub-group as part of the Covid-19 Planning and Response Group but was reliant on NHS organisations working locally to identify flex in their systems to accommodate delivery of both routine and essential services,

146. There are many more examples of NHS Wales activities during this period. To list them all in this statement would be an impossible task but hopefully this provides the Inquiry with an overview of the sorts of pandemic related functions and responsibilities NHS Wales had. My Accountable Officer Letters exhibited in my statement reference M2B-HSSG-01 provides fuller detail and more will undoubtedly be detailed in the subsequent healthcare systems and impact modules planned by the Inquiry.

Other Welsh bodies which were important contacts for NHS Wales during the pandemic

147. As outlined above, one of the strengths of NHS Wales was its size and close proximity of its organisations to each other and to the structures of Welsh Government. This was also true in the case of other bodies in Wales which enabled NHS Wales access to a range of support and information in planning and responding to the pandemic. I have outlined below some of the larger national bodies which NHS Wales would have worked with but highlight that locally there would have been other important contacts for NHS Wales. NHS Wales would also have worked closely with local authorities, social service directors, third sector organisations, and emergency services in their local areas in addition to working within the RPBs and PSB models I have outlined above.

Life Sciences Hub

148. Life Sciences Hub is an arm's length body of Welsh Government. It aims to 'catalyse innovation and collaboration between industry, health, social care and academia'. They work closely with health and social colleagues across Wales to understand the challenges and pressures an organisation may face. Once identified, they work with industry to source and support the development of innovative solutions to respond to these challenges. They currently run four programmes: Digital Health Ecosystem Wales, Accelerate, Intensive Learning Academies Wales and The Academy of Medical Sciences Cross-Sector Programme.

149. In March 2020 the Life Sciences Hub established contact points for various workstreams that they were undertaking which included, medical devices (including ventilators), infection control/point of care testing, digital solutions and social isolation and loneliness. In the early stages of the pandemic there was a groundswell of support

from various parts of Wales offering to help to develop PPE and new technology to support NHS Wales tackle the outbreak. The Life Sciences Hub co-ordinated this support and fed into NWSSP and worked closely with Public Health Wales on diversification of testing in Wales.

Health Technology Wales

150. Health Technology Wales is a national body working to improve the quality of care in Wales. They collaborate with partners across health, social care and the technology sectors to ensure an all-Wales approach. They are funded by the Welsh Government and hosted within NHS Wales, but independent of both. They cover any technology or model of care and support in health and social care that isn't a medicine. For health, this could include medical devices, diagnostics, procedures and psychological therapies. For social care, this could include equipment, or different models for supporting families, children, adults and the workforce.

151. HTW worked to support NHS Wales in responding to the pandemic, it was also a collaborating partner of the Wales Covid-19 Evidence Centre. During the pandemic the organisation contributed to Welsh Government committees and task forces, co-authored three pan-European collaborative reviews and provided scientific advice to industry.

Genomics Partnership Wales

152. Genomics Partnerships Wales was founded by the Welsh Government to deliver 'The Genomics for Precision Medicine Strategy'. This strategy was developed by a Welsh Government-led genomics taskforce. The delivery of this plan included interlinkages with the Pathogen Genomics Unit in Public Health Wales. During the pandemic that relationship continued with both organisations working on Test, Trace, Protect and assisted in brining genomic sciences into our understanding of the pandemic.

Health and Care Research Wales

153. Health and Care Research Wales is a networked organisation which brings together a wide range of partners across NHS Wales, local authorities, universities, research institutions, third sector and others. Its work is led by the Chief Adviser for Research in the Population Healthcare Directorate at the Welsh Government and the Director of Health and Care Research Wales, with a team within the Research and Development Division of the Welsh Government which has responsibility for health and social care research policy, strategy and funding. Health and Care Research Wales is accountable, via Research and Development Division and the Chief Medical Officer,

to the Minister for Health and Social Services. During the specified period the Wales Covid-19 Evidence Centre was established as part of Health and Care Research Wales. The Evidence Centre aimed to improve the quality and safety of health and social care delivery by ensuring Covid-19 research is timely and applicable to Wales and undertook a range of research for NHS Wales and for the Technical Advisory Group and its sub-groups.

Academic partners, including Swansea University

154. NHW Wales worked with a number of academic partners to deliver the response to Covid-19. Welsh Universities at the start of the pandemic worked to provide solutions on medical devices, ventilators, supplies and PPE. This was co-ordinated by NHS Wales Procurement Service who was also working with industry to provide additional equipment for Wales. A number of Welsh academics also participated in the Technical Advisory Group and its sub-groups working closely with NHS Wales and Welsh Government officials and technical advisors. Additionally modelling SAIL Databank which was part of Swansea University provided an intelligence led approach to Covid-19 data to inform the response.

NHS Wales working with four nations and UK Government departments

155. Four nations work around public health advice to Ministers and the Welsh Government was a core feature, not least at a senior NHS Wales clinician level and through the CMO and TAG. This allowed for the sharing of intelligence and for collaboration in critical areas, recognising the number of areas a co-ordinated approach is desirable and in the best interests of the public. Of course, that does not mean that there were not areas of divergence between nations. PHW led the way with engagement on behalf of NHS Wales with the other three nations and had close links with Public Health England and subsequently with the UK Health Security Agency.

156. Early in the pandemic NHS Wales via NWIS and primary care colleagues worked with DHSC colleagues on the categories of the highest risk individuals requiring protective shielding. This was essential to ensure the establishment of the Shielding Programme in Wales which was overseen by the CMO office.

157. Test, Trace and Protect ("TTP") included integrated testing capacity and capability under the wider UK National Testing Programme ("NTP") alongside specific Welsh testing sampling sites run by Health Boards, processed at NHS Wales laboratories and sequenced by the PHW Pathogen Genomics Unit. This approach provided us with the ability to scale up wider population testing alongside prioritising testing within the Welsh system for critical workers, patients and outbreaks. The significant scaling up of testing

required substantial digital developments for test results to be recorded and transferred across digital systems. This continually evolved as technology and policy developed, and from 2021 this included additional work on the NHS Covid app and NHS Covid pass. To deliver this there was significant collaboration with the UKHSA, NHSX, NHS Digital and DHCW.

NHS funding during Covid-19

158. Despite the challenges posed by the pandemic, nine of the 11 NHS organisations operated within their budgets in 2020- 2021 and 2021-22. In 2020-21 Hywel Dda and Swansea Bay University Health Boards were unable to balance their books in-year, reporting deficits in line with their initial plans developed prior to the pandemic. The overall outturn for NHS Wales was a deficit of £48m, an improvement from £89m in 2019-20 despite the circumstances of the pandemic. The summarised accounts for NHS Wales were laid before the Senedd in August 2021 and are exhibited to the statement, reference **AGMB2NHSW01/42-INQ000182567**. Hywel Dda and Swansea Bay University Health Boards continued to report deficits in line with their initial plans developed prior to the pandemic in 2020. The summarised accounts for NHS Wales were laid before the Senedd in August 2022 and are exhibited to the statement, reference **AGMB2NHSW01/43-INQ000182566.** As I outlined at the start of this statement the NHS Wales is funded by the Welsh Government and the HSS Main MEG includes funding for NHS Wales. It is important to note that while NHS Wales was in deficit the overall HSS MEG was able to offset the deficit as a result of considered funding decisions throughout the pandemic period which enabled the HSS MEG to be balanced.

NHS Wales role in decision making by the Welsh Government during the Covid-19 pandemic in respect of NPIs

159. Throughout the pandemic advice to ministers stressed the importance of mapping capacity across NHS Wales to inform decision making around the imposition and non-imposition of Non-Pharmaceutical Interventions (“NPIs”).

160. As I outlined in M2B-WG-01 and exhibited in **AGMB2NHSW01/44-INQ000182406,** ‘Leading Wales out of the Coronavirus pandemic; a framework for recovery’ described the Welsh Government’s intended approach to leading Wales out of the pandemic. The recovery framework was based on three pillars which were:

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

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

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

161. NHS Wales was central to all three pillars. Pillar one considered NHS Wales capacity with Health Boards providing regular updates to Welsh Government and working to build additional capacity and resilience in order to protect the health and care system from becoming overwhelmed. In respect of pillar two, the CMO(W) and CSA for health worked closely with NHS Wales senior clinical advisors through TAG and TAC and with PHW to develop the scientific advice provided to Welsh Ministers. Finally, pillar three involved the work of Public Health Wales, Health Boards and HSSG officials working on contract tracing in Wales which provided essential information on the transmission of the virus in Wales and the effectiveness of the impositions put in place. When the vaccination programme commenced and vaccine status was linked with contract tracing this gave us a better understanding of the impact of the vaccine on transmission and NHS capacity, providing essential triangulation and assessment.

162. PHW was particularly instrumental in its work. The Chief Medical Office wrote to Tracey Cooper, Chief Executive PHW, in April 2020 outlining the 'tests' the First Minister had committed to which would inform the lifting of social restrictions in Wales and requesting PHW's support on developing a plan for the operational model for health protection in Wales, a surveillance plan for Wales and a plan for learning from international experience. PHW contributed to all these areas.

163. As I have sought to set out in this statement, NHS Wales was integral to this process but any advice to Ministers was via the senior officials in the HSSG or by myself, as Chief Executive NHS Wales. I have outlined in detail in my statement referenced MB2-HSSG-01 my role, and later Judith Paget's, at Cabinet meetings in providing Ministers with as close to real time as possible assessment of NHS capacity and the impact of Covid-19 on the NHS and wider care sector and outlined the significance this had on decision-making at each of the 21-day reviews. I will not reiterate the position of NHS Wales at each 21-day review in this statement but refer Inquiry to that evidence.

NHS capacity and ventilators data

164. The need to build capacity in NHS Wales was recognised early in the pandemic and the CMO(W) wrote to health bodies on the 13 February 2020 to highlight the need to increase capacity across the NHS estate to manage possible Covid-19 patients who require admission. It was not clear at that early stage what level of capacity was required but this was subsequently confirmed using the UK-wide methodology developed by Imperial College, London. 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. This scenario was based on a 40% reasonable worst case scenario ("RWCS") and, given the then rate of transfer, it was anticipated that Wales would see peaks in demand over the next 3-4 weeks. This position was also informed by the experiences that were being seen in Italy and Spain who were tracking a number of weeks ahead of the UK at the time.

165. In order to address capacity issued the NHS in Wales had three principal approaches:

i. Stepping down of services/non-Covid activity;

ii. Field hospitals and additional local capacity; and

iii. Use of the private sector.

166. I will briefly touch upon all three to reflect on how they impacted assessment of NHS capacity and the role of NHS Wales in informing that assessment, however conscious that these will also be considered in detail in subsequent modules.

167. On the 13 March 2020 I met with the NHS Chief Executives to discuss capacity and step down of services. It was recognised that departments were losing staff to sickness already and there were concerns about more staff shortages. The MHSS agreed make a statement at 4pm that day about health bodies releasing activity in order to support organisation in preparation for the expected increase in demand. The statement issued that day set out a framework of 10 actions which health bodies could locally assess and action as required. The 10 actions included the suspension of non-urgent outpatient appointments, non-urgent surgical admissions and procedures and NHS emergency service and health volunteer support to mass gatherings and events. Urgent appointments would be prioritised along with access for emergency and urgent surgery. The framework of actions also included expedited discharge of vulnerable patients from acute and community hospitals.

168. In addition to the above actions by health bodies, the Welsh Government also took steps to support the increase of capacity across the NHS by working with NHS Wales. On the 20 March 2020 the MHSS 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.

169. On the 27 March 2020 the MHSS was briefed by WG officials on the need to increase staffing levels to deal with the extra strain on the health and social care system and mitigate against the significant number of staff that will be unable to work. The Minister was asked to agree the strategic deployment of nurse, midwife, medical and paramedical students, and associated costs and the strategic deployment of Allied Health Professionals ("AHP") and healthcare scientist students, and associated costs.

170. On the 4 April 2020 I wrote to the Health Boards to discuss their capacity plans which had been submitted to outline the levels of additional critical care and acute beds that they were targeting to bring online in the coming months and weeks.

171. Health Boards were asked to plan for an increase in national bed capacity of up to 10,000 beds, including provision for intensive care, with a capacity assessment provided for each Health Board area. To achieve this target, each Health Board developed its own local field hospital infrastructure including plans for additional local capacity, using the Step-Down Model which allows the transfer of non-critical patients (non-Covid and Covid) to Field Hospitals prior to discharge, freeing up capacity in the main hospitals.

172. On the 16 April 2020 I wrote to NHS bodies about capacity and use of field hospitals. Wales was at this time already in the first peak and the fact that we were to a large extent managing within surge capacity that was developed in NHS settings was due to the considerable actions taken to plan ahead and to reduce the non-Covid-19 work in the initial few weeks.

173. The proposals for field hospitals were explored jointly between NHW Wales, the military (using their experience and expertise of logistics and military field hospitals) and Welsh Government officials. The option of a 'Nightingale style' central hospital, as established in England, was considered but discounted partly due to concerns about ensuring equity across Wales and concerns about patient outcomes associated with longer transfers.

174. While there were a number of Ministerial Advice submissions (MAs) relating to field hospitals for the approval of funding, written statements, reviews and updates, operational control over field hospitals rested with individual Health Boards. The following advice was submitted by Welsh Government officials in the HSSG relating to field hospitals:

MA/VG/1151/20	Advice on establishing a field hospital in Cardiff Principality Stadium **(AGMB2NHSW01/45-INQ000136769)**
MA/VG/1223/20	Cardiff Principality Stadium revised cost estimates **(AGMB2NHSW01/46-INQ000275570)**
MA/VG/2068/20	Field Hospitals position statement **(AGMB2NHSW01/47-INQ000235939)**
MA/VG/3011/20	High level review of field hospitals (**AGMB2NHSW01/48-INQ000136817)**

175. The governance and accountability route for field hospitals, and broader additional/surge capacity requirements beyond field hospitals, was through bi-monthly 'quality and delivery' (Q&D) meetings in each Health Board.

176. In the first wave of the pandemic, there were 19 Field Hospitals in Wales. While field hospitals in non-NHS settings were a key aspect of NHS Wales response and the right action to pursue based on intelligence and the scientific evidence during March and early April, I did request at the end of April 2020 a pause and review of the requirement for the scale and size of field hospitals going forward to balance the anticipated Covid-19 demand with a re-introduction of non-Covid-19 activity. During this period we were also able to consider the impact of NPIs and lockdown measures on the projected demand and capacity needs.

177. The Field Hospital and Surge Facilities Support Group was established to provide national support and co-ordination around local planning and delivery of care to patients in field hospitals. The Group met fortnightly between April and June 2020 and reported to the HSSG Covid-19 Planning & Response Group, via Chris Jones, Deputy Chief Medical Officer.

178. Additionally, a Welsh Government-led Field Hospital Operational and Clinical Leads Peer Group was established. The Group operated through the summer of 2020 on an informal basis and was formalised in November 2020. The Group, which included representatives from all NHS Wales organisations with field hospitals facilities, met fortnightly to share situation reports, lessons learnt, best practice points and to escalate risks where necessary. Welsh Government Officials also conduct weekly 1:1 meetings with Health Board field hospital leads, where a facility was open and receiving patients.

179. NHS Wales provided assurance to the Welsh Government that it was able to provide the additional level of capacity outlined my letter dated 24 June 2020 where I wrote to all Health Boards setting out the revised recommended level of additional surge

capacity required to enable management of an increase in Covid-19 activity (in what we referred to as a realistic worst case scenario). From September the Welsh Government asked Health Boards to retain 5000 additional beds based on the Welsh Government's data modelling and the system experience to date.

180. RWCS planning for NHS Wales from March 2020 – September 2020 was based on the model agreed by SAGE on 31 March 2020. In July 2020 TAC asked that Armakuni and Swansea University to develop RWCS models for Wales. Based on recommendations from TAG (on the 21 August 2020) based on the Swansea University delayed response model and was agreed as the RWCS for Wales in September 2020. The model was updated in December 2020 to account for the changes in the position in Wales following the 'fire-break' period but did not change the NHS Wales planning model which erred on the side of caution so changes to the RWCS did not exceed the 5000 additional beds and 350 ICU beds that the NHS was asked to flex up and was aligned to the extant national planning advice. The RWCS was updated again for Wales in February 2021 again with no impact on NHS Capacity plans as still did not exceed the 5000 bed request.

181. Health Boards in setting up field hospitals were responsible locally for their establishment and local teams were set up working with the local Medical Directors, Nursing Directors and senior clinicians to ensure they had workable options for set up and also utilised the knowledge and skills of the military planners embedded in each Health Board. Taking the example of the Dragon's Heart Hospital in Cardiff, this was led by Cardiff and Vale Health Board. The Health Board completed a rapid options appraisal led by the Director of Transformation working with the Medical Director, Nursing Director and Chief Operating Officer. A Strategic Co-ordinating Group (made up of all the Health Boards Executive Directors) approved the recommendation to commission the Principality Stadium for the purpose of setting up a field hospital. The Medical Director and Nursing Director agreed clinical pathways for the facility and the Nursing Director also leading on the staffing model required. The Health Board came to the Welsh Government for agreement of the capital funding and revenue costs associated with running the facility.

182. A number of assurance reviews were undertaken. A high level paper was compiled and reflected on the planning, development and delivery of field hospital facilities as at June 2020 and the direction of travel for their use, based on the latest available predictive data modelling for future activity, exhibit **AGMB2NHSW01/49-INQ000227392** refers. It concluded the planning response to identify and secure premises and equip field hospitals with 6,000 beds within a matter of 8-10 weeks was

highly commendable and a testament to collaboration across Health Boards, Local Authorities, the independent sector and the military.

183. On 24 November 2020, Simon Dean, Deputy Chief Executive of NHS Wales wrote to Health Boards to seek assurance about the quality and governance regarding field hospital environments and provided a 'Field Hospital governance checklist' to assist health boards with their local planning arrangements to help ensure a consistent approach across Wales. A copy of this letter is exhibited in **AGMB2NHSW01/50-INQ000227272** and the checklist in **AGMB2NHSW01/51-INQ000227273.**

184. Data was captured on all patients admitted to a field hospital / temporary facility during the pandemic period. The data from the 1 April 2020 for field hospitals was published as part of the NHS activity and capacity during the Coronavirus (Covid-19) pandemic as exhibited in **AGMB2NHSW01/52-INQ000227408.**

185. Both the Welsh Government's internal audit service and NWSSP separately undertook a review of the use of field hospitals during the pandemic period. A copy of the Welsh Government internal audit report is exhibited in **AGM3WGO01/53-INQ000022593.**

186. Private hospital capacity was also commissioned across Wales providing additional outpatient, diagnostic and inpatient capacity for non-Covid-19 care. WHSSC led on the contractual arrangements with independent providers commissioning the agreed services on behalf of the Local Health Boards in Wales. While led by NHS Wales, input from the Welsh Ministers was required on key areas. The response from the independent sector was professional and appropriate and helped to provide resilience in our response. On the 25 March 2020 the MHSS agreed to the sum of up to £30m funding towards the costs of commissioning additional private sector capacity. Part of these arrangements required Welsh Government officials to work with the UK Government to disapply Competition Act restrictions from agreements between NHS Wales and independent healthcare providers to manage Covid-19. An order was required to be made by the Secretary of State to allow NHS Wales to enter into agreements to procure additional capacity from private providers to manage the Covid-19 outbreak without infringing the Competition Act. The UK Government made an equivalent order to disapply Competition Act rules for agreements in England.

187. The collective response across NHS Wales was nothing short of extraordinary, more than doubling the historic critical care capacity in a few weeks and forming plans for additional field/surge hospitals. As noted above we were working on the basis of 40% RWCS approach and it was essential that the Welsh Government had a clear understanding of the ability of NHS Wales collectively to deliver to that level over a 3-

to-4-week period. While extreme surge guidance was drafted and rationing of intensive care considered in readiness this guidance was never finalised or issued. It was not required as we had sufficient capacity in the system. The hope was always that any additional capacity made would be underused –which thankfully it was. The capacity used was influenced not only by the NHS preparation and plans, but also by the impact of the NPI and lockdown decisions that were made that prevented exponential increases in demand and patients. However, the preparation and commissioning of capacity still had to happen.

NHS Wales data collection

188. From late March 2020, the Welsh Government's Knowledge and Analytical Service ("KAS") coordinated, with input from NHS Wales, a number of daily (7-day-a-week) data returns to the both the Welsh and UK Governments. The scope of the daily dashboard return was varied and grew considerably over time. It initially covered topics such as testing, cases, deaths, ventilators and hospital activity. It grew to include a range of metrics on care homes, staff absence, shielding, food parcels, school attendance, cancer referrals and more.

189. 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 decision making on the need for the imposition or non-imposition of NPIs. The weekly output became monthly from April 2022 onwards. The most recent output was on the 11 August 2022 and a copy of this is exhibited above in **AGMB2NHSW01/52-INQ000227408.**. This included data on critical care beds in use in Wales and the numbers for those invasive ventilated. The HSSG also received daily Sitreps from some Health Boards in September 2020 linked to the local lockdown interventions, as exhibited below:

    a. Covid-19 - Summary of cases of COVID-19 (between 13-19 September) by Local Authority & Daily Situation Reports (as at 21 September) for areas identified for intervention, **AGMB2NHSW01/54-INQ000353116.**

    b. Covid-19 - Summary of cases of COVID-19 (between 14-20 September) by Local Authority & Daily Situation Reports (as at 22 September) for areas identified for intervention, **AGMB2NHSW01/55-INQ000353121**

    c. Covid-19 - Updated Summary of cases of COVID-19 (7 day period up to 23.59 on 22 September) by Local Authority & Daily Situation Reports (as at 24 September) for areas identified for intervention, **AGMB2NHSW01/56-INQ000353136.**

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

191. In addition to the modelling work led by TAC in conjunction with Swansea University, NHW Wales also undertook further data modelling work under the leadership of Andrew Sallows (performance director). This supplementary modelling work was based on NHS Wales operational data, trends ad experiences and provided the ability to track predictions against overall Covid-19 demands, hospital admissions and intensive care capacity – this proved to be fundamental in informing timely decision making by NHS Wales to prevent the system from becoming overwhelmed. Andrew Sallows worked closely with the Chief Scientific Adviser for Health at Welsh Government and with the Technical Advisory Group Modelling forum. I understand the Chief Scientific Adviser for Health has provided a corporate statement on behalf of the Technical Advisory Group and will be more appropriate to address modelling as a topic in detail. I have exhibited to this statement in exhibit **AGMB2NHSW01/57-INQ000300189** the Technical Advisory Group's Modelling Retrospective published in June 2022 which provides an excellent summary of the work in Wales.

Ventilator capacity

192. As outlined above the daily dashboard in March 2020 and subsequent data provided information on the number of ventilators available to NHS Wales– both the invasive and non-invasive types. This was closely monitored by NHS Wales and Welsh Government.

193. At the start of the pandemic, NHS Wales had 415 ventilators in Welsh hospitals which could provide invasive ventilation. There were a further 349 anaesthetic machines with ventilator capacity and 207 non-invasive ventilators. During 2020 an additional 1,238 ventilators were procured by NHS Wales and through UK arrangements. This included 450 invasive ventilators via UK arrangements, 270 dual purpose (invasive or non-invasive machines) procured by NHS Wales and 518 non-invasive machines) via UK arrangements.

194. During 2020, 713 additional Continuous Positive Airway Pressure ("CPAP") machines were procured either by NHS Wales or by UK arrangements which included 206 UCL/Mercedes F1 machines as part of the national challenge.

195. In addition to this the Welsh Government supported initiatives to support the manufacture of ventilators such as the participation by the Advanced Manufacturing

Research Centre (AMRC) Cymru in hosting the rapid manufacturing of ventilators as part of a consortium of businesses united under the VentilatorChallengeUK initiative.

196. The Military Liaison Officers embedded in Health Boards assisted in the monitoring of a range of matters including ventilator capacity which would reported on as a part of the daily sit rep. Additional the Technical Advisory Cell would also include as part of its advice on the lockdown reviews a summary of NHS capacity which included the number of ventilated beds across NHS Wales.

Public health communications

197. I have outlined in my statement M2B-WG-01 role of the Welsh Government Health Strategic Comms team and the strong existing networks in place between the Welsh Government HSS communications team and Health Board communications teams. While public communication campaigns such as the Keep Wales Safe' campaign were led by the Welsh Government, we relied on amplification by local partners such as NHS Wales and local authorities to highlight the key messages to the public about safety and access to NHS Wales services. These key messages were adapted and built on by individual organisations as part of the quarterly operational planning framework.

198. The first phase of this national campaign covered six key pillars - Emergency Departments, GP surgeries, Maternity Services, Child Health (Emergency Departments, Vaccinations and Diabetes), Mental Health and Cancer Services. The campaign included social media and digital, press adverts and radio. There was a particular focus on a key pillar each week. Activities included a combination of Ministerial mention in a daily session, a press release highlighting the issues, video content and stakeholder promotion.

199. In addition to the planned campaign NHS bodies would also be asked directly to provide comment to local news outlets or, in particular, Public Health Wales officials would be asked to provide information for press articles and news stories.

200. As the public face of NHS Wales, I committed to weekly press conferences when required in the initial phases of the pandemic from March to September 2020, later switching to press updates as required often at times when public concerns were higher or the NHS in Wales was under visible pressure. I remained mindful of the need for clear and transparent communications, and an honest conversation with the population of Wales to build public confidence in NHS Wales planning and preparation and an understanding about the pressures faced by NHS Wales at this time – reinforcing the message of “Stay Home; protect the NHS; and save lives”. These public

communications enabled me to convey the progress, as well as the challenges, across the range of issues being addressed by NHS Wales. I hope that this helped to instil some trust and confidence in NHS Wales and the way in which it exceptionally prepared.

Future Risks and lessons learned

201. 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. As I have outlined NHS Wales was working closer than it ever had before and having to do new and innovative things that they have 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.

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

203. During the specified period the Welsh Government, working with health, social care and other partners, including Audit Wales, Bevan Commission, Life Sciences Hub and WCVA, 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 **AGMB2NHSW01/58-INQ000066469** refers. This study report was delivered through a 'Team Wales' approach, by a dedicated project commissioning group consisting of leads from Aneurin Bevan University Health Board, HEIW, 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 collaboration demonstrates what is achievable in Wales as a small but highly networked nation with an integrated policy environment for health and social care. 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.

204. The aim of the report was to understand what novel and innovative practice has emerged as a result of Covid-19 demonstrating successful themes and case studies that could enable, scale and sustain innovative and transformative ways of working across NHS Wales. The intended purpose was to provide NHS Wales with a practical report to which would enable them to embed the learning and recommendations into their organisations as they plan for the future.

205. As outlined in this statement, NHS Wales is built on a strong planning precedent which incorporates as part of the 3-year planning cycle a requirement for all NHS organisations to consider local lesson learning as well as how organisations can adopt and deliver national strategies, objectives and recommendations. Individual organisations within NHS Wales hold that information.

Statement of Truth

I believe that the facts stated within this witness statement are true to the best of my knowledge and belief.

Full name: Andrew Goodall

Position or office held: Permanent Secretary

Signed: **Personal Data**

Date: 4 December 2023