Witness Name:	Judith Paget
Statement No.:	1
Exhibits:	59
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF JUDITH PAGET

I, Judith Paget, will say as follows: -

Preface

1. The purpose of this statement is to assist the Inquiry to investigate key government decision making within the Welsh Government, the information relevant to such decisions and the role of senior officials and advisers.

2. My response to the Inquiry's request for evidence made under rule 9 of the Inquiry Rules 2006, referenced M2B/NHSW/JP/01, will cover the period from the 1 March 2020 and May 2022 (which I will refer to in this statement as "the pandemic period") and the information provided in this statement is structured as follows:
    a. **Part A** – will provide my professional background
    b. **Part B**- will provide an overview of my role as Chief Executive of Aneurin Bevan University Health Board up to October 2021.
    c. **Part C** – will provide an overview of my role in Welsh Government as Chief Executive of the NHS in Wales from November 2021.
    d. **Part D** – will provide information and responses spanning the whole of the pandemic period.

3. In order to fully address the Inquiry's request for evidence on the matters outlined in Part B of this statement I have engaged with Anuerin Bevan University Health Board ("ABUHB") in order to have access to documentation and information covering my period of time there. I am grateful to the Inquiry for agreeing to this, and to colleagues in ABUHB for assisting in this.

PART A

Background and qualifications

4. I hold a Diploma in Management Studies and a Master of Science, Primary Care Policy and Management from the Health Services Management Centre at the University of Birmingham.

5. I have worked for 43 years within NHS Wales and a copy of my CV is attached as exhibit **JPM2BWG01/01-INQ000239577**.

6. I began as a Clerical Officer for Community Health Services in South Gwent in 1980, after which I held a number of management roles in hospitals and Health Authorities. I joined the Aneurin Bevan University Health Board (ABUHB) in October 2009 as Director of Planning and Operations/Deputy Chief Executive, in September 2012 I was appointed as Chief Operating Officer/Deputy Chief Executive and in June 2014 I was promoted to Chief Executive.

7. As the Chief Executive at ABUHB I was responsible for managing all aspects of the Health Board's activities, including improving population health and patient services, performance and strategic partnership working, all aspects of governance and staff leadership. Providing advice to the Health Board on all aspects of Board business and, as Accountable Officer, specifically on matters relating to probity, regularity and administration. I led ABUHB's response to the Covid 19 pandemic until I left in October 2021.

8. I was appointed to the role of Interim Chief Executive of the NHS in Wales and Director General of the Health and Social Services Group in November 2021. I was made permanent in this role in June 2023.

9. The role of Chief Executive NHS Wales is not a statutory role but 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 the NHS in Wales.

PART B

B. Role as Chief Executive of Aneurin Bevan University Health Board

10. In January 2020 I was Chief Executive of Aneurin Bevan University Health Board (hereafter "ABUHB"), having been appointed in 2014. When the pandemic began in January 2020, I had been in post for about 6 years. I remained in post until 30 October 2021 when I was appointed Interim Director General for Health and Social Services and Chief Executive for NHS Wales.

11. ABUHB is one of the seven Welsh Local Health Boards ("LHBs") responsible for planning, securing and delivering primary, community, mental health and acute hospital health services in Wales and acts as both commissioner and provider of services in its area, with consequent responsibility for the health of the local populations. ABUHB is responsible for the local populations of Newport, Torfaen, Monmouthshire, Caerphilly and Blaenau Gwent.

12. The Chief Executive is the Accountable Officer for ABUHB with full responsibility for the continued development and management of the Health Board. The Chief Executive provides top level leadership, vision, inspiration and strategic direction and management across all aspects of the Health Board's activities. In my role as Chief Executive, it was my responsibility to ensure that all required decision making, control, delivery and development systems were in place. The Chief Executive is accountable for providing advice to the Board on all elements of Health Board business and specifically on matters relating to probity, regularity and administration. As one of the cadre of senior leaders within Wales, I was also responsible for contributing to the wider health and organisational agenda of NHS Wales and Welsh Government ("WG"), including working with Public Health Wales ("PHW") and other agencies to lead on the improvement of population health, reduction in health inequalities and the broader public health agenda. I have exhibited to this statement a copy of the CEO job description as **JPM2BNHSW01/01-INQ000236772**.

13. The Chief Executive also takes a lead role at a national level. This includes being a member of the NHS Wales Leadership Group, working with the former NHS

Wales Collaborative[1] (hosted by PHW), and WG. These responsibilities extend to leading and delivering as the senior responsible officer (SRO) on wide-reaching NHS public service initiatives. I was the CEO lead for the National Strategic Programme for Primary Care and the SRO for the roll out of 111 Cymru with programme staff for both programmes hosted by ABUHB. In that capacity I was involved in work to ensure the NHS 111 service, as it was in the early stages of the pandemic, was able to deal with the demand for information, advice and assistance received via the website and telephone line. I was also involved in providing oversight and leadership with the National Strategic Programme Team for Primary Care and the 111 Programme for NHS Wales.

14. Although my key responsibilities and accountabilities did not change during the pandemic, my day to day role changed dramatically. In my role as CEO, I was responsible for the oversight of ABUHB's response, structures, plans and resources, military engagement and the operational implementation of Welsh Government advice, policy and directions. The initial focus became operational planning, setting up strategic command arrangements and collapsing our business as usual structures. As we were in immediate planning and response mode, we initiated and deployed our incident command structures (Gold, Silver, Bronze),with the Executive Team acting as the Gold Strategic Command. We also increased remote working, holding shortened and more focussed meetings and agreeing temporary changes to the Scheme of Delegation to support rapid decision making through the streamlined Covid structure. We had originally anticipated that the pandemic curve would be similar to a flu pandemic which would usually last around 12 weeks, but it became very quickly apparent this would have a much longer lasting impact for NHS services, patients and our staff.

B.1 Overview of Relationship with Welsh Government

15. In my role as Chief Executive Officer (CEO) of ABUHB, I had regular contact with the Chief Executive of NHS Wales, Dr Andrew Goodall CBE, in meetings (including remote meetings via Microsoft Teams) and also through telephone calls and emails. We also occasionally exchanged text messages. As Chief Executive for

[1] Dissolved on 31.3.23 and absorbed into the NHS Wales Executive.

NHS Wales and Director General of the Welsh Government Health and Social Services Group at the material time, Dr Goodall was responsible for the strategic leadership and oversight of all NHS Wales.

16. Prior to the pandemic, there was regular interface between Health Board clinical and non-clinical staff at various levels with WG officials on a range of policy development and service planning issues. This was in addition to the usual interaction around performance management and oversight of the Health Board's delivery of Ministers' key priorities and targets. One of the main collective interfaces between the NHS and WG was the monthly NHS Wales Leadership Board meetings (referred to as NHS Wales Executive Board meetings until July 2021), which were chaired by the Director General of Health and Social Services/CEO of NHS Wales (Andrew Goodall). These were attended by the CEOs of each of the NHS Wales statutory organisations and the Directors of the Health and Social Service Group of WG. These meetings dealt with a wide range of topics including NHS finance and performance, service and workforce planning and service quality developments. During the pandemic, whilst some business as usual topics continued, it was also a forum to share information on the pandemic.

17. During the course of the pandemic, the NHS Wales Leadership Board continued to be held on a monthly basis (save for February 2020, March 2020, April 2020 and August 2021 when no meetings were held) and discussed business as usual topics in addition to the NHS Wales Covid-19 Framework and Covid-19 related issues such as the impact of Covid on other services, health equity and population health.

18. In the early part of the pandemic, the DG HSS/CEO NHS Wales, Andrew Goodall also set up weekly Chief Executive Calls, which included all NHS CEOs and some directors from Welsh Government. The frequency of these meetings started at three per week but this varied at times and then tapered down over the course of the pandemic.[2] There was no agenda for these meetings during the pandemic as

[2] CEO Covid meetings took place twice a week in July 2020 and between 29 October 2020 to 26 March 2021; and once a week between 1 August and 25 October 2020 and from 29 March 2021 onwards.

they were reactive and the issues covered varied in response to the rapidly changing situation. Notes of the meetings were taken by the Welsh NHS Confederation and they produced what I would describe as an action note.

19. The weekly Chief Executive calls usually began with an update from Andrew Goodall about the current situation what WG was doing in response and he would then take views from all CEOs about what was happening on the ground and what was needed. Along with the other CEOs, at these meetings I would highlight any issues of concern and where necessary request guidance from WG on particular issues that arose during the pandemic. Andrew Goodall would inform the meeting whether guidance was available or would be forthcoming. Issues raised included bed capacity, oxygen supply, equipment supply including support for expansion of ABUHB ITU with additional ventilators, care homes support, testing capacity and mobilisation, impact on BAME staff and risk assessments, military support, private hospital capacity, community transmission increases, firebreak arrangements, staff sickness absence and impact on service delivery, vaccination programme plans and deployment, winter planning and demand escalation.

B.9. Informal Communication

20. I did not use WhatsApp or any other messaging groups to communicate with Welsh Ministers, senior advisors or senior civil servants. The only informal communication I had with WG was through telephone calls and as above the occasional text message to Andrew Goodall. As I have changed roles and I am no longer in possession of the allocated mobile telephone used for these communications, I do not have access to these text messages at this time. However, my recollection is that the only relevant text message communication between myself and Andrew Goodall was in relation to the supply of ventilators as described below.

B.2. Initial Response to Covid-19: January – March 2020

21. I have refreshed my memory of events by reviewing various documents including my own notebooks, relevant correspondence between ABUHB and other public bodies, including WG, written submissions and briefing papers produced by ABUHB and the minutes of key meetings that I attended during this period.

22. It is difficult to recall precisely when I first became aware of the Covid-19 virus in my professional capacity, however, having reviewed the minutes of Leadership Board Meetings that I attended on behalf of ABUHB it was on 21 January 2020 that the Chief Medical Officer (CMO), Dr Frank Atherton, provided an initial update on the Coronavirus in Wuhan, China to all CEOs of NHS bodies across Wales. At that stage we were informed that 279 cases had been reported with 6 deaths and the threat to the UK had moved from very low to low. An incident group had been set up across the four nations and the CMO stated that we needed to think about our plans for the isolation of patients and the safe transfer of patients by ambulance if the virus came to the UK. We were informed that advice for primary care would follow shortly as this would become of increasing importance. I have exhibited to this statement the minutes of this meeting as **JPM2BNHSW01/02 - INQ000236778.**

23. On 27 January 2020, the Health Board's Executive Team[3] discussed a letter about the Coronavirus received from the CMO Frank Atherton. The letter, dated 24 January 2020, advised all CEOs of the need to ensure robust plans were in place and rehearsed in Wales so that we could identify, isolate, test and if necessary provide care for patients with Coronavirus for a minimum of 24 hours before onward transfer to a specialist treatment centre. The letter attached a checklist to be completed and returned to the CMO in order to provide him "with the necessary assurance on NHS preparedness across Wales." The deadline for returning this document to Welsh Government was the 31 January 2020. The Health Board had identified isolation cubicles for the care of coronavirus patients at the Royal Gwent Hospital, PPE training and FIT testing of masks had been completed for staff who would be deployed to work in those areas, and planning for community testing of

[3] The Executive Team is the mechanism through which the Chief Executive co-ordinates the management of the organisation. It has a leadership and co-ordinating role in the efficient, effective and appropriate planning, operation and monitoring of the Health Board's day-to-day internal and external business and relationships. The Executive Team is an important source of advice to the Health Board on key issues as they apply to the role and corporate responsibilities of the Health Board. The Executive Team approves key organisational policies, procedures and strategies in line with its authority and the Scheme of Delegation of the organisation and also acts as Risk Management Operational Group where key organisational risks are discussed and actions agreed.

symptomatic members of the public was underway in conjunction with Public Health Wales.

24. On 31 January 2020 there was a conference call between ABUHB and PHW at which the need to review emergency plans was discussed.

25. On 3 February 2020, Dr Sarah Aitken (Executive Director of Public Health between January and March 2020 and appointed Interim Medical Director of ABUHB on 30 March 2020) provided an update to the Health Board's Executive Team on the Coronavirus, highlighting the first case in the UK and confirming that three people were being tested locally (the first referral for a home test being made to PHW on 1 February 2020). There was discussion regarding transporting patients and Sarah Aitken advised the Team that it would be more logical to send trained people out to individuals rather than bring them to hospital and she would convey this to PHW. It was agreed that Sarah Aitken would be the Executive Lead during the containment phase. The Assurance checklist, received with the CMO's letter of 24 January was sent back to WG on 3 February 2020, a few days after the deadline initially given. I exhibit to this statement a copy of the completed checklist as **JPM2BNHSW01/03-INQ000236771.**

26. On 12 February 2020 the Executive Team met to discuss the current position following the WHO announcement in which the novel Coronavirus was named as Covid-19. I did not attend this meeting.

27. WG had indicated that it would like Community Testing Units to be put on acute hospital sites, should the demand outweigh capacity for home visits; however, my preference was for the Community Testing Units to be situated on community sites. I cannot recall having any direct conversations with WG/PHW on the location of testing sites but can recall discussing this with colleagues in the Health Board. We determined that asking potentially unwell covid patients to attend busy acute hospitals for a test would present an unnecessary risk and that community testing centres should be set up in other locations. By 17 February 2020 a community testing service had been established and a small number had been tested. There was a general discussion about communication and direction from PHW and WG

and it was confirmed that whenever any new guidance was circulated from WG or PHW this should be updated and shared with all departments and services without delay. The Infection Control Team was also sending out updated action cards and the intranet was being updated with the new information. It was agreed that amplifying the PHW messages was needed at that point and Sarah Aitken and James Hodgson, Head of Communications, took responsibility for preparing an organisational message on the current situation and a message in the event that a positive case was confirmed in Wales.

28. I do distinctly remember when going into the February 2020 half term (17 to 21 February 2020) there was a lot of anxiety regarding what was going on in the rest of the world. In particular as people were going on holiday/skiing there was concern about Italy and southern France. During this period, planning and preparation in the Health Board continued at pace. By 18 February all clinical areas who would be working in the designated care pathways for symptomatic patients had been trained in the use of the required personal protective equipment. The PPE/FIT testing programme was extended to other areas, options for the extension of community testing were developed and there was scenario planning for all potential patient presentations. Testing guidance that remained in place was for symptomatic patients with a relevant travel history. On 28 February 2020 the first Covid 19 case in Wales was confirmed.

29. Guidance was issued (I believe by the UK Government) on 1 March 2020 which included advice for healthcare professionals and the general stay at home guidance, which was received via PHW. The Health Board along with PHW, contributed to requests for updates from local public service partners via the Gwent Local Resilience Forum under the Civil Contingencies Act 2004. Incident plans were in place with the Local Resilience Forum (LRF).

30. The first community confirmed case in the ABUHB was on the evening of Sunday 8 March 2020 and my understanding was that they were the first community case confirmed from PHW, being a returning traveller from Italy. As at 9 March 2020 the ABUHB incident plan and LRF plan were in place. An Incident Control Centre had been established at the Headquarters of the Health Board. Well patients were to

be tested in cars and symptomatic patients in PODS. On 10 March, following a change in the case definition to allow for testing of patients with no travel history, a patient tested positive for Covid 19 at the Royal Gwent Hospital. This patient had been admitted to a smaller local general hospital, Ysybty Ysrad Fawr, on 6 March 2020 after presenting medically unwell some days earlier and been transferred to the Royal Gwent Hospital as their condition deteriorated. The patient had subsequently been admitted to ITU at the Royal Gwent Hospital where they tested positive for Covid 19. This brought the number of confirmed cases in Wales to 6.

31. From that day there was a rapid increase in the number of Covid 19 patients /staff in our Health Board area with a large number of people in our communities, patients and staff affected. A Critical Incident was declared by the Health Board on 11 March 2020 and actions taken in line with our escalation plans.

32. On 12 March 2020 the Minister for Health and Social Services, Vaughan Gething, announced the roll out of virtual consultations in Wales, which was led by ABUHB as the host of TEC Cymru for WG. WG had invested in a pilot introduced by ABUHB called "Attend Anywhere." This was a platform that had been rapidly deployed by our Digital and IT Team which provided clinicians with the facility to conduct a medical consultation with patients remotely using video. Virtual consultations were rolled out across all GP practices in the ABUHB area within two weeks.

33. I wrote to Andrew Goodall on 12 March 2020 to inform him we had declared a critical incident in response to the evidence of community spread and clinical presentation of a high number of Covid 19 cases in our area. The email set out in detail the extraordinary measures the Health Board was taking at that stage, including the decision to cancel all non-urgent elective activity for 48 hours, and sought confirmation from WG that we could go forward with the next stage of our plans around service change to deliver capacity and resilience. I exhibit the email dated 12 March 2020 as **JPM2BNHSW01/04-INQ000236775**.

34. On 13 March 2020 WG announced the suspension of non-urgent NHS appointments, see **JPM2BNHSW01/04a-INQ000375348** One of the thrice weekly

calls with Andrew Goodall took place on Wednesday 11 March which was the day we declared a critical incident. I would have spoken to him the day before I sent the letter on 12 March. On 13 March 2020 a staff email broadcast was sent on behalf of Gold Command explaining that we were reviewing the visiting policy and limiting visits to essential visitors only.

35. As set out above, emergency management and incident command protocols were established with the Executive Team acting as Gold Strategic Command and the Bronze structures slightly revised from the original plan to include additional Bronze/ Operational teams. ABUHB's Covid-19 Command Structure was introduced on 12 February 2020 while in the Containment Phase and adjusted by the Covid-19 Strategic Group on 25 March 2020. I exhibit a diagram which describes the structures and various other levels of support that were put in place as **JPM2BNHSW01/05-INQ000236773**.

36. The impact on staff absence was significant and the number of clinical and non-clinical staff who were now isolating with symptoms was creating significant issues for service delivery as locum and agency staff cover could not be sourced. On 13 March we were able to negotiate with Public Health Wales that we could test staff who were critical for service delivery. A Coronavirus Testing Unit (CTU) for testing of key healthcare workers was set up in Llanfrechfa Grange Hospital site on 14th March 2020 and protocols were rapidly established and immediately deployed. Senior staff volunteered to call staff when test results came through late in the evening and worked with operational managers to resolve roster issues and cover for the following day.

37. On 15 March 2020 there was a discussion between PHW and ABUHB regarding positive/negative hospitals. I don't recall being involved in this discussion but I do recall having discussions within the Health Board about the wisdom of running positive and negative hospitals, which I thought was sensible in theory but was never going to work operationally as by 15 March we had Covid positive patients in at least 3 of our acute hospitals (RGH, NHH and YYF).

38. In response to WG's request for mass testing, ABUHB established a Community Testing Unit at Rodney Parade in Newport on 26 March 2020. The Rodney Parade Unit, managed by the Health Board, was designed as a drive-through population-sampling centre and had capacity to accommodate 600 tests a day, together with home testing for certain groups. Following agreed governance arrangements, testing of Gwent Local Resilience Forum (GLRF) partners at Rodney Parade commenced on 17 April 2020, in line with a request from Public Health Wales.

39. Once Covid-19 arrived in Wales, in my opinion WG took appropriate steps to respond to the seriousness of the threat and there was no delay in communicating the steps being taken to ABUHB. On reflection, I do think that there needed to be earlier testing of symptomatic patients in hospitals without a travel history, subject to testing capacity being available at that stage. However, I do not consider myself to have sufficient knowledge or information to comment on whether the testing capacity could or should have been there earlier. For the same reasons I do not feel able to express an informed view about decisions made in respect of international travel and border control. With the benefit of hindsight, I would say that it would have been wise to impose restrictions on international travel ahead of the February half term but I am commenting as an uninformed observer and I would not know if this was considered and discounted by WG or UK Government ("UKG"). I do not know all of the matters that needed to be considered or what was practically or legally possible.

40. In terms of alignment of decisions, during the initial period from January to March 2020, I do not think it would have been practical or possible for WG to have taken different decisions to the UKG. It was a worldwide pandemic and a novel virus. It appeared that little was known about it at that stage so everyone had to work together to understand and respond to the implications. It is difficult for me to comment as I don't know what WG thinking was at that time but I don't think it would have been possible or practical to take different decisions in Wales and act independently of the UKG. My only reflection is that if the case definition for testing was extended sooner to include anyone in hospital with symptoms (not just returning travellers) some of the early outbreak issues we faced at the Royal Gwent Hospital and Ysbyty Ystrad Fawr might have been prevented. However, the

WG response was so entwined with UKG on so many issues not devolved to Wales, I think it was quite difficult.

41. Later in the pandemic WG did take different approach with slight variations from the approach in England in relation to matters such as Test, Trace, Protect and the easing of restrictions. However, in my opinion the initial national lockdown had to be a national lockdown. In the absence of anything else it was the only strategy the UKG and WG could deploy. My understanding was that this was based on scientific advice and was intended to reduce transmission. I am not in a position to know what other options were considered but I can see the logic of the decision and I think the seriousness of the situation warranted extraordinary measures.

42. I am not sure of the practicalities of organising a UK-wide lockdown down any earlier but 23 March 2020 feels sufficiently timely given that the WHO did not declare the pandemic until 11 March 2020. When the lockdown decision was announced I remember being surprised and relieved that action was being taken based on the evidence that was available with the aim of protecting people and preventing the transmission of the virus.

B.3. Engagement with the Welsh Government

43. The initial contact with ABUHB from WG regarding the Coronavirus was through the Director of Public Health, Sarah Aitken. In the beginning, as it was very much a public health issue, there were conversations around the Director of Public Health network into Public Health Wales and also the CMO. As stated above, the first interaction was through the CMO who provided an update on the Wuhan Coronavirus at the Leadership Board meeting on 21 January 2020 which was followed by a letter from CMO on 24 January regarding a preparations checklist.

44. In my role as Chief Executive of ABUHB I was present or chaired the vast majority of Strategic Gold Group meetings for the Health Board. In addition to the 3 times weekly calls with Andrew Goodall and the monthly NHS Wales Leadership Group meetings, a number of Ministerial meetings (with the Minister for Health and Social Services) were held with CEOs during the period to discuss Covid 19, at which we were encouraged to share our local experience and situation.

45. The Health and Social Services Group Covid-19 Planning and Response Group had been meeting since 20 February 2020 and the Health Board had been participating in those meetings. The group started meeting weekly, and moved to bi-weekly (although pattern frequency stood up and down over the pandemic) and our representatives at the meetings were the Head of Emergency Planning (Wendy Warren), the Director of Public Health (Sarah Aitken), the Deputy Medical Director/Director of Primary Care and Community Services (Dr Liam Taylor), and the National Programme Director for 111 Wales (Richard Bowen).

46. Andrew Goodall rang me on 3 March 2020 (I believe he made contact with every CEO that day) to confirm that the UK Coronavirus Action Plan had been published that day and that this was a joint plan between UKG and the 3 devolved Governments. He confirmed that we remained in the 'Contain Phase' of the plan but that we should step up planning in preparation for an escalating situation and a Reasonable Worst-Case (RWC) scenario provided by WG. Infection prevention control measures and availability of isolation rooms with negative pressure ventilation were discussed. He also briefed me on the arrangements he had put in place within the Health and Social Services Group of WG and these arrangements were subsequently confirmed in a letter of 5 March 2020. I exhibit the letter from Andrew Goodall dated 5 March 2000 a **JPM2BNHSW01/06-INQ000236767.**

47. As described above, Andrew Goodall would also arrange to speak with NHS CEOs 3 times a week (the CE-Covid Call – Monday, Wednesday and Friday) for communication, and coordination of response. Due to the early and intense impact of Covid 19 in the ABUHB area, in these CE Calls, we were able to share with WG and other NHS colleagues what impact Covid 19 was having on our services, our staff and our health and care system. This included communicating about practical issues around obtaining test results in a timely way and ensuring access to additional ITU equipment such as ventilators. We also communicated our worry about oxygen supplies to acute hospitals to support the increased number of patients needing ventilation and had discussions about step down capacity for recovering patients, diagnostic capacity, mortuary capacity and general capacity and planning. Other issues flagged to WG included national discussions regarding

the release of SPA (supporting professional activities) time, national diagnostic pathways, consideration being given for relaxing the provisions of the primary care GMS contract, resilience of 111 and out of hours services, and stepping down all usual performance management arrangements. The deepest efforts were trying to deliver a safe but speedy response.

48. Specifically, on Wednesday 25 March 2020 it was suggested that a minimum of 1,500 to 2,000 ventilators were needed. Testing was to be increased from 500 per day to 800 per day by Friday 27 March and 1,100 per day from the following Tuesday, and up to 2,800 per day in April. At that time there was 11 weeks of PPE stock at the then current run rate.. On 1 April 2020 there was discussion about a different mechanism for the supply of oxygen and Wales being involved in a four nations approach to this. At that meeting ABUHB explained that modelling assumptions were critical to the capacity plan and the use of circa 350 beds at the Grange University Hospital was considered. At that time there had been 274 new positive cases and 29 deaths. The challenging nature of nursing homes and the need for support was recognised.. Existing supplies of oxygen were recognised to be of concern. Furthermore, critical care nursing expertise was identified as an issue in particular due to the critical care staffing ratios.

49. In March 2020, we initially felt the modelling data being provided by the Welsh Government was not helping us determine the likely demand for hospital/ITU care because of the rapid increase in Covid 19 cases we had experienced both in the Newport area and the Royal Gwent Hospital. We had been working with our clinical teams to review bed capacity plans and options for Covid positive inpatients, those who would need ventilation or support in one of our two ITUs and the likely numbers who would be recovering in hospital at one time. We therefore used our own assessment of the likely impact of the virus to calculate how many beds we might need. I recall that the Chief Operating Officer (COO), the Director of Planning and I spent one Sunday in March 2020 with flipcharts and whiteboards calculating how many beds we would need and how to make those beds available across our hospitals in the heat of the response. We were very fortunate because we had two local general hospitals with 100% single rooms, although neither would be able to offer HDU or ITU care. However, the single rooms were large and gave

us the option of doubling up positive or recovering patients in a worst case scenario.

50. In response to a letter dated 4 April 2020 from Andrew Goodall, the ABUHB Director of Planning wrote to the WG Delivery Programme Director, Andrew Sallows, on 6 April 2020 to clarify the Health Board's plans to respond to the forecast demand associated with the Covid-19 pandemic. In that letter Nicola Prygodzicz also asked WG to provide further clarity on the underpinning model assumptions provided by WG.

51. WG had asked us to consider what field hospital capacity we might need to respond to the RWC. We were also part way though the construction of a 460 bedded new hospital (known as the Grange University Hospital) which was due to open in the Spring of 2021. This hospital had 75% single rooms and was felt to be ideal for step down/recovering Covid patients. Following discussion with the contractor and WG, we agreed to advance complete the ward block to give us the option of opening 384 beds plus some ancillary services by the end of April 2020. There was also the potential for this number of beds to be further increased by another 232 beds with the doubling up of patients in large single ensuite rooms if required. This was subsequently agreed by WG as part of their field hospital programme. Additional capacity was also secured at St Joseph's Hospital Newport, as ring fenced 'green capacity' for very urgent elective surgery/cancer care.

52. Later in 2020, WG introduced more local restrictions where community case numbers had increased. The first of these was in Caerphilly County Borough which was announced on 6 September but came into effect on 8 September 2020. I recall meeting with the CEO of Caerphilly County Borough Council at our offices to work through the planning and implications of this with our Director of Public Health and her team. Meetings were held with the First Minister, Council Leader and other officials to take soundings from local partners before decisions were made by WG. My recollection is of a similar process, and conversations related to a similar local lockdown in Torfaen. Other local restrictions were introduced in other parts of Wales in September and October 2020.

53. The communication with Welsh Government continued to be regular both formally and informally through staff networks. Guidance to the NHS was issued regularly and covered many issues, such as infection control, care homes, hospital visiting. These were also updated regularly. One of the reflections I have is the frequency with which the infection control guidance was being updated. I recall our Consultant Nurse in Infection Control undertaking a review many months into the pandemic of the number of changes to the infection control guidance we had implemented - it was very substantial. All of the guidance was always communicated and implemented immediately, and the Health Board Control of Infection Team worked swiftly to ensure advice to staff was issued and advice posters updated.

54. In relation to the NHS Wales Leadership Group, this continued to meet monthly during 2020 and 2021, although the meetings in February, March and April 2020 were cancelled. I always prioritised these meetings. They took place with a pre-arranged agenda usually determined by Andrew Goodall. Although it was more 'business as usual' agenda topics, as set out above, it also offered up an opportunity to discuss the Covid situation and I frequently raised issues in this forum, such as:

    a. At the meeting on 19 May 2020 the CMO raised a concern about people who need urgent hospital care not accessing it and there was some discussion about changing the messaging. We were informed that there had been positive conversations with colleagues in NHS England about capacity and field hospitals and there was to be a four nations planning meeting about capacity. I expressed the view that we must take a step by step approach and not look too far forward.
    b. On 24 August 2020 I reported the number of Covid-19 patients in hospitals in ABUHB but social distancing was still causing some issues and hospital staff were learning and adjusting.
    c. On 17 November 2020 I outlined my concerns about the figures in Blaenau Gwent, noting community transmission was very high. Andrew Goodall explained that the Cabinet were looking at what restrictions to enforce post firebreak.

d. At the meeting on 15 December 2020, I raised the issue of what elective care would look like after the pandemic and noted that Coronavirus will no doubt have created further inequalities in communities and we needed to start thinking about how we will support these communities in the future. Andrew Goodall explained that he was worried about older people spending too much time in hospitals and indicated more could be done for medically fit patients.
e. In the context of a discussion about reset and recovery work during the meeting on 19 January 2021, I explained that ABUHB was pushing on mental health and highlighted that Covid had led to huge inequalities in our communities and we needed to think further on how we approach it. Andrew Goodall agreed that it would be useful to have a discussion on mental health at the February Board meeting and stated that the Minister for Mental Health, Wellbeing and Welsh Language was pushing on this work and will want an update.
f. When discussing the performance overview dashboard on 16 March 2021 and referral to treatment times, I stated that although we were in a different place to earlier in the year, it was necessary to keep in mind the high level of staff absences. Andrew Goodall explained that the current WG tone remained a very cautious approach to unlocking however he stated this might change over the next few months with numbers and hospital admissions likely to fall.
g. At the 18 May 2021 meeting I expressed concern about a number of cases in the Newport area and informed the meeting that I had not stood down any of the Health Board's Covid-19 structures. Andrew Goodall stated that we were still in a public emergency and it was important to keep contingencies in place for the moment. He also stated that was important to think about Covid-19 recovery and I stated that although staff were tired, they were keen to start recovery and to do things a bit differently. We were told that the Minister was keen on transformation.
h. On 22 June 2021 when discussing vaccinations, I acknowledged that the vaccination programme and TTP were doing very well but non-Covid-19 demand was becoming overwhelming. I alerted colleagues to a rise in staff sickness levels despite some having received both vaccinations and raised concerns by staff and older people about when they would receive a third vaccination. When discussing recovery, I explained that I was struggling to see what the approach was to how we move the system forward.

i. On 17 July 2021 I raised the issue of the language used when discussing recovery as although Covid-19 cases were lower, the NHS was still dealing with the harm and consequences of the pandemic and despite it being suggested we were in recovery, it did not feel that way due to sustained pressures. Andrew Goodall responded that WG were constantly reminding people nationally on the tone for the next steps, emphasising that we remained in a public health emergency and may need to take steps back.

j. On 20 October 2021 I expressed concerns about the recent increase in cases in the ABUHB area. Andrew Goodall reminded colleagues that the local choices framework had been updated and re-circulated and was there to be used. When discussing recovery work, I also explained that ABUHB had made a system change in that we had separated out emergency and elective work at the end of 2020 and we were seeing the benefit on elective activity.

55. On 21 May 2020 Sarah Aitken and I gave evidence to the Wales Health, Social Care & Sports Committee (HSCSC) regarding events in the ABUHB area during the early weeks of March 2020. We provided a timeline of patients in general hospital beds and critical care beds who had tested positive for Covid in ABUHB Hospitals from 1 March to 10 May 2020. The graphs provided in our paper showed the rapid increase in early March which accelerated and reached a peak around Easter weekend on 10 to 13 April 2020 when we had 49 patients in critical care where the maximum capacity within ABUHB was 28 patients. Had the lockdown measures not come into effect two weeks earlier, we felt that the peak would definitely have been higher.

56. In our submissions to the HSCSC we highlighted the difficulties caused by the Government's testing strategy prior to 9 March 2020 and shared the outcome of ABUHB's internal investigation which concluded that there was evidence of community spread of Covid in Gwent by 6 March 2020, which was consistent with the rapid acceleration of the outbreak in our area from that point in time. I exhibit to this statement a copy of the written submission provided to the HSCSC as **JPM2BNHSW01/07-INQ000236774.**

57. It was a busy and intense time in which we tried to learn from others and share what we had learnt. We obtained as much intelligence as we could, reading journal articles and listening to experts in terms of what they were saying and getting advice from WG as it became available around case projections. The modelling data from WG became more helpful as time went on.

Involvement in WG Decision-Making

58. In terms of the key decisions taken by WG at the beginning of the pandemic, including the discussions around testing, I did not play a direct role in those decisions or the evolution of WG guidance. As indicated earlier in this statement, there was a regular flow of information from me and my Health Board into WG throughout the whole time covered by this statement.

59. I can recall one specific time when we when we needed additional ventilators as demand in our area was particularly high. WG had purchased a significant number of additional ventilators and they were held in storage by NHS Wales Shared Services Partnership (NWSSP) to be distributed equally on a 'fair shares' basis to each Health Board as needed. The ITU team had escalated their concerns about the risk to patients and the urgent need for more ventilators and having contacted NWSSP, I was advised that my Health Board had received its allocation and they could not agree to release anymore to us as this was at the direction of WG. I contacted Andrew Goodall by phone and by text message, and having explained the situation we agreed there were only two options 1) we were allocated more ventilators or 2) our patients would need to be transferred to another ITU outside our Health Board area. He agreed that the ventilators should go to the areas that needed them and a further 10 ventilators were allocated to ABUHB. These were received on 24 March 2020 and after raising concerns, the number was increased by another 20 on 3 April 2020.

60. This was good example of us working together across the system and the closeness of the system that allows you to speak quickly and constructively to resolve practical issues to support safe patient care. My overriding reflection is a sense of 'we are in this together' and so we were learning and responding together.

Information sharing

61. From my perspective most information was shared between the NHS and WG in the meetings referred to above. I did not attend the WG Planning and Response Meetings, which were attended by colleagues from the Health Board Planning Team. However, I know there was regular contact between members of my Executive Team and their peers across NHS Wales with their respective WG lead, e.g. Nurse Directors with the CNO, Workforce and OD Directors with the WG Workforce Director, Medical Directors with the CMO/DCMO etc. Through the different disciplines, everyone was sharing information, knowledge and understanding and planning ahead as much as was possible.

62. In terms of Wales wide meetings, I attended the National Strategic Programme Board for Primary Care, which I chaired and the 111 Wales Programme Board. These meetings were attended by WG representatives, including the Deputy Director of Primary Care, representatives from other NHS Wales statutory organisations and local government representatives. During the pandemic topics discussed at these meetings included reflection and learning from the response of primary care services to Covid-19, the Strategic Programme for Primary Care and the Out of Hours/111 Programme. I did not attend any UK wide meetings.

63. On 20 March 2020 Andrew Goodall wrote to all Health Board Chief Executives setting out the WG requirement to designate Covid-19 Coordinators and Covid-19 Reporters who would be responsible for providing a daily Covid report to WG on critical care capacity and activity. The information was to be provided at specified times during the day, seven day a week and was to be used to provide advice to Ministers and Senior Officials in WG to make decisions about responding to the pandemic. I attach the letter and Standard Operating Procedure as exhibit **JPM2BNHSW01/08-INQ000236769.**

64. In terms of collecting, providing and sharing data we set up our own internal system of data collection. We created our own spreadsheet which was completed every day by our Informatics Team and circulated by 11am. It told us how many staff had been tested and how many tested positive and the same for patients. It also included how many were in ICU, the age profile and where they were. That was

our operational monitoring system in terms of the impact which allowed ABUHB to monitor numbers increasing or reducing and we all used that daily for any conversations with WG. The data was used for our local planning and response purposes. The spreadsheet data related to hospital patients only and encompassed all hospitals and all staff employed by the Health Board. Test, Trace Protect data was also available to us but from a separate data system.

65. I believe the test result data fed into the PHW surveillance system. The data was published daily on the PHW dashboard. I believe it was PHW who provided that information to WG.

66. In terms of sharing of data relating to waiting lists, planned care activity was suspended in March 2020. We continued to collect our data and national reporting recommenced in the form of Statistical Briefings by WG in November 2020 which included reporting for the previous months. An Essential Service Framework was issued by Welsh Government to support the NHS during the pandemic and the Health Board ensured it was compliant with the requirements of that Framework. The Essential Service Framework provided LHBs and NHS Trusts with a range of options in relation to suspending services and redeploying staff in response to significant peaks in Covid-19 cases. I attach to this statement as exhibit **JPM2BNHSW01/09-INQ000236768** the letter from Andrew Goodall explaining the framework and options, dated 10 December 2020.

67. The majority of the modelling and scientific data on Covid 19 was shared with the Health Board via the HSSG Planning and Response Group or via the meetings I attended with Andrew Goodall.

68. I felt there was a good flow of information between WG and the Health Board. There was a good collaborative approach on testing, the vaccination programme and my Health Board colleagues were well engaged in the planning and response arrangements. I genuinely felt WG made every effort to keep channels of communication open. I was mindful that this was a novel virus and the situation and evidence was unfolding. There was no playbook for this virus and we worked

through the most appropriate response with the combined aim of trying to keep everyone safe during a very worrying and frightening time.

69. I have described above my contact with Andrew Goodall. Access to Andrew Goodall was good and my perception was he was always accessible all the way through my time as CEO of ABUHB, including weekends.

70. I think WG were very open in sharing what they did know and also clear when they didn't know. In a sense it was frustrating that they couldn't give us accurate modelling in March 2020 but once we understood the complexities, we understood the difficulty of doing modelling in the early days. Later they were able to commission modelling data from academic institutions and this did help but there were always uncertainties in the modelling and we worked with a number of scenarios locally for planning purposes.

71. My recollection is that when we said, 'we need this' or 'there is a problem with that', we generally had an appropriate response from WG. An example is ensuring a consistent flow of PPE, which never ran out and making sure we had sufficient ventilators as detailed above. There were ad hoc issues but we were able to work with other Health Boards to overcome these, for example, we were given some CPAP machines from Hywel Dda Health Board and borrowed some items of ITU equipment from Betsi Cadwaladr University Health Board. I recall we also had a particular issue with the vulnerability of the oxygen supply to support the ICU at Nevill Hall Hospital. My recollection is that NWSSP were unable to sort a supplementary supply for us so our Chief Operating Officer rang numerous suppliers to locate large oxygen concentrators and eventually located a supplier in the USA. In that sense we got on with it and did what we needed to do.

B.4. Non pharmaceutical interventions (NPIs)

72. On 7 September 2020 I attended a meeting with PHW, representatives of Caerphilly County Borough Council, Gwent Police and WG representatives at which the Covid-19 rates in Caerphilly were discussed. At the request of NR NR Chief Environmental Health Advisor to WG, we were asked to submit our proposed interventions for Caerphilly. We were informed that following the

meeting specialist adviser input would be obtained at WG level to ensure the most appropriate and effective actions were taken to protect public health and minimise other harms.

73. At the NHS Leadership Board meeting on 20 October 2020 **(JPM2BNHSW01/09a - INQ000236784)**, the 17 day 'circuit break' lockdown imposed on 23 October 2020 was discussed and Andrew Goodall asked the board for their comments on lockdown and the NHS. On 22 October 2020 an email was circulated to members of the Covid-19 Intelligence Group, Directors of Public Health and Directors of Public Protection seeking comments and feedback on a list of proposed options for a post firebreak national regime. I can also recall a Teams meeting with WG colleagues when considering the lifting of the local restrictions in our area at which I expressed some nervousness, not so much about the lifting of the firebreak but what would happen next as we headed towards the winter months.

74. At the NHS Leadership Board meeting on 17 November 2020 **(JPM2BNHSW01/09b - INQ000236785)** Andrew Goodall explained that there was a general downwards trend in hospital admissions following the firebreak but nosocomial transmission remained a concern. I outlined my concerns about the figures in Blaenau Gwent as the community transmission was very high at that point. Andrew Goodall explained that the Cabinet were looking at what restrictions to enforce post firebreak and confirmed that a mechanism would be put in place around Merthyr. Everyone at the meeting was made aware that Ministers were concerned about a rise in cases over the Christmas period and the CMO informed the meeting that local measures could be put in place.

75. In December 2020 I was very anxious about the increase in Covid numbers. We had opened our new hospital at the Grange University Hospital 5 months early to support our response during the winter. This allowed us to centralise emergency and critical care services, and paediatric and consultant lead maternity services onto one hospital site. On 21 November the community transmission rate for our area was 245.4 cases per 100,000. Community incidence continued to rise and by 1 December we were continuing to see a rise in positive cases across our Health Board area with a case rate of 315.7 cases per 100,000 with Blaenau Gwent CBC

area then the highest in Wales at 453.8 cases per 100,000, and Torfaen CBC area the third highest at 402.3 cases per 100,000.

76. Planning for Winter pressures had been underway since August 2020, and the Gold Strategic Group triggered a further escalation of response measures to support the system. The weekend of 12/13 December 2020 was very difficult operationally, with the increase in community transmission now impacting on increased hospital attendances and staff sickness.

77. I made contact with Andrew Goodall by phone on the weekend of the 12 December to update him on the situation and the actions being taken. It was a very challenging environment and although we were doing everything operationally possible, it was a very worrying situation and our whole system was under significant pressure from Covid19. By 15 December, the case rate in our area was 481.9 cases per 100,000 with Blaenau Gwent at 505.3, Newport at 537.0, Caerphilly at 587.4 and Torfaen at 434.2, which were all significantly higher than the all-Wales average of 377.8 per 100,000.

78. Although our vaccination programme had started on time and was making good progress, it had yet to have an impact on community transmission with community contacts increasing in the run up to Christmas. I was really worried by what I was seeing and had a sense that we were going into something that might prove unmanageable for our health and care system. I was aware that the impact of Covid 19 on the NHS had been a priority in WG's thinking since the beginning of the pandemic. Hence, I alerted Andrew Goodall to the situation.

79. This was picked up in the NHS Leadership Board meeting on 15 December 2020 **(JPM2BNHSW01/09c - INQ000236786)** when Andrew Goodall explained that we had reached a very difficult point in that 19 of the hospital sites in Wales were at level 4. He informed the meeting that the Minister was concerned that the system was at tipping point and this was echoed by the CMO who expressed his concerns about how quickly the virus was spreading again in Wales, noting that 1 in 120 people now have coronavirus. We were informed that the CMO had a call with the other Chief Medical Officers later that day and there would be calls for a lockdown.

A discussion followed about whether a national response was needed and Andrew Goodall stressed that it was for the NHS to indicate whether national measures were needed. On 16 December 2020 the First Minister announced that Wales would move to alert level 4 from Christmas Day with restrictions on household mixing, staying at home, holiday accommodation and travel applying from 28 December 2020.

80. Save as described above, I cannot recall playing any role in the provision of information or data for any other local or regional restrictions or in respect of working from home, reduction of person to person contact, social distancing or self-isolation. My recollection is that all such action was through Public Health advice rather than management and leadership advice. Similarly with schools, face coverings and border controls. I had no involvement beyond being present at some meetings for example where the CMO might give an update on face coverings or social distancing but it would not be for me to contribute to such decisions – it was more incidental involvement such as me seeking advice about how things would work in practice. There was constant sharing of what we were doing and had found, but nothing specific.

81. From very early on in the first wave of the pandemic my colleagues and I in the Health Board were concerned about the disproportionate impact Covid 19 was having on people from Black Asian and Minority Ethnic Groups. We asked a Consultant in Public Health from our Local Public Health Team to compile an evidence base of the disproportionate effects of Covid 19. This was considered by the Gold Strategic Group on 21 April 2020 at which I circulated a copy of a letter received by WG from the British Association of Physicians of Indian Origin (BAPIO) in relation to the disproportionately high mortality rates in the BAME population. Geraint Evans was to pick up the issue on the national call with Directors of Workforce and Organisational Development. A second part of the work was then commissioned, aimed at identifying individuals who were from ethnic minority backgrounds and who worked for the Health Board and assessing them to protect those most at risk. The work culminated in a risk assessment tool which was implemented in our Health Board in April 2020. It was also shared with local partners and with WG. On 30 April 2020 a Gold Group meeting took place (which

I did not attend) and at which it was agreed our work would be shared with WG for use as the Welsh approach at that time. On 1 May, WG issued this for implementation across NHS Wales while further work they had commissioned from a BAME Covid 19 Advisory Subgroup took place. I exhibit this risk assessment tool from April 2020 as **JPM2BNHSW01/10-INQ000236796.**

82. Our Director of Public Health (subsequently Interim Medical Director) Sarah Aitken did a significant amount of work to raise the profile of Covid 19 and its consequences with our local community and through media briefings. The Local Resilience Forum also operated a Warn and Inform group. The work undertaken on our staff risk assessment meant that we were very aware of the disproportionate impact on Black Asian and Minority Ethic people living and working in our community.

83. In relation to data, the Health Board was required to complete and submit to PHW a comprehensive proforma for each Covid related death that occurred in our hospitals. This proforma included the name, date of birth, date of death, borough of residence, underlying health conditions, date of admission and hospital pathway. Later in the pandemic this also included vaccination dates. These were sent each day to PHW for review. Deaths from Covid 19 in the community were reported via the ONS.

84. The analysis of the data from across Wales was undertaken in Public Health Wales and shared with Welsh Government to inform policy.

85. NHS Wales also established its own digital information system to support the vaccination programme - Wales Immunisation System - through which we were able to interrogate to understand where vaccination uptake had not been as strong, whether by geographical area or by ethnic background and we were then able to target vaccine clinics to those communities or geographies where vaccine equity had been an issue.

86. In terms of sharing that information with WG; the Covid 19 vaccination programme was overseen by a National Programme Board made up of representatives from

WG, the NHS and other key stakeholders. The data on uptake by target population and geography was available to that group to support the successful oversight of the vaccination programme.

87. Neither ABUHB or I had any other involvement providing information or advice to WG about how NPIs would impact upon different groups including those who were at risk, vulnerable and/or with protected characteristics or how NPIs would impact upon existing inequalities in Wales.

B.5. Local lockdowns and restrictions

88. I did feel ABUHB were sufficiently consulted regarding the decision to impose local lockdowns and restrictions. The first local 'firebreak' was in Caerphilly County Borough on 8 September 2020 and later there were local restrictions introduced in Newport, Torfaen and Blaenau Gwent areas. As described above, we were engaged by WG in conversations around the data on case transmission, current impact of Covid on local NHS services and the implications of introducing such restrictions for staff and our services. As described above, I attended a meeting with Caerphilly County Borough Council, Gwent Police and Public Health Wales on the morning of the 7th September following a request from the CMO to submit advice to WG regarding the cases in that area. I also recall, and as set out in more detail above, we were engaged in conversations at Ministerial level before these local restrictions were introduced. More broadly than that I took the view that WG were making decisions in the context of national data, supported by scientific evidence and advice. Throughout I held the view that WG were taking decisions in the interest of protecting the people of Wales, with the impact on the NHS and the ability of the NHS and its staff to cope and not be overwhelmed central to their thinking.

89. As indicated above, the transmission rates in our local communities increased considerably from the second half of November, and although there was a move by WG to bring forward the planned Christmas mixing restrictions, we experienced significant challenges with Covid demand and staff absences which did not ease at all until mid-January 2021. I was able to raise an opinion on the releasing of lockdown in 2021 in the NHS Wales Leadership Board: at the meeting on 23

February 2021, I expressed the view that there should be a slow releasing of lockdown as we were still in emergency response mode and staff absences were still very high, especially in critical care. I explained that hospitals also needed to be reconfigured back to what they were before Covid-19 and there was still a risk of nosocomial transmission. I also explained that I was concerned about staff wellbeing now and in the future and stressed that we needed to ensure the messaging to staff was right.

90. Although there was some concern expressed by border communities about the differing restrictions applying in England and Wales there were no issues that had an impact on the NHS that I can recall.

B.6. Care Homes

91. Care homes were a constant feature of conversations with WG from the early weeks of the pandemic onwards.

92. I can recall being concerned about care homes and the wellbeing of care home residents from early in the pandemic. Following an outbreak very early in the first wave of the Coronavirus at a care home in the Blaenau Gwent area, we requested the nurses from our Continuing Healthcare Team and the Infection Control Team visit the home to assess the situation and offer support and advice. General issues were identified: PPE, patient testing and the consistent update and application of infection control guidance. In response we brought key people together (CHC Infection Control, local Public Health Team, and representatives Blaenau Gwent Social Services Department) to agree a support package and input to the home. We had established an Enclosed Settings Cell as part of our Incident Control Centre and worked collaboratively with the sector, Local Government (EHOs) and PHW to ensure training, testing, tracing, results monitoring and surveillance activities were in place. The main function and role of the enclosed settings cell was to mitigate against further spread of COVID-19 when confirmed cases were identified in enclosed care settings.

93. Given the value of this and ongoing risk of Covid outbreaks in other care homes and closed settings in our Health Board area, on top of the Enclosed Settings Cell,

a Closed Settings Strategic Group was also stablished within our response structures on 6 April 2020 and was chaired by Nick Wood, the Executive Director of Primary Community and Mental Health Services. The role of this Group was to guide and coordinate the effective delivery of the Gwent community response to Covid 19 in enclosed settings and provide a decision making forum in line with the Incident Control Centre. Its overall objective was to minimise avoidable harm and mortality through infection prevention and control and supporting the sector. It reported to the Health Board's Gold Strategic Group with membership extended to all 5 Directors of Social Services and EHOs of our 5 Local Authorities. We took the view that our care homes were an extension of our care system and we should do what we could to support care home residents and their staff. As commissioners of care for our population, our responsibilities extended to those we had assessed and placed in a care home with a package funded by the NHS.

94. Public Health Wales also established a national Closed Setting Cell (e.g. care homes, Prisons etc.) and our team were in regular contact with them.

95. There were concerns that discharges from hospitals were the cause of the outbreaks in care homes, I can recall research being undertaken by Public Health Wales which started in our area and expanded to across Wales suggesting that large care homes were at considerable greater risk of outbreaks and after adjusting the for care home size, discharge from hospital was not associated with a significant increase in risk (Emerson C et al (2020), 'Risk factors for outbreaks of Covid-19 in care homes following hospital discharge: A national cohort analysis' *Influenza Oher Respiratory Viruses, 2021; 15: 371-380)*. The Health Board followed the guidance issued by Welsh Government at all times and worked constructively with Local Authorities to support care homes.

96. On 14 March 2020 I received a letter from Andrew Goodall to the NHS which included advice to 'fast track placements to care homes by suspending the current protocol which gives the right to a choice of home'. The Health Board was required to submit plans by 17 March 2020 which indicated how it would implement this action. We submitted our plans on the 18 March 2020.

97. I do not believe I was personally consulted about WG's decision to discharge asymptomatic patients from hospital to care homes without a Covid-19 test during March and April 2020 but there may have been discussions with the Director of Public Health.

98. On 22 April 2020 I received a joint letter from the CMO and the Deputy Director General notifying the Health Board that updated WG Guidance was to be issued on *Covid-19 Hospital Discharge Service requirements (Wales)* and *Guidance for stepdown of infection control precautions and discharging Covid-19 patients*. The letter indicated that all individuals being discharged from hospital to live in care homes would be tested regardless of whether or not het were admitted to hospital with Covid-19 and WG would be extending testing to people being transferred between care homes and for new admissions from the community. There was also to be an agreed discharge pathway for people who test negative prior to discharge from hospital. I attach a copy of that letter as exhibit **JPM2BNHSW01/11-INQ000236770.** I do not recall being personally consulted in respect of WG's decision to test before discharge in late April 2020 but I would have every expectation that WG would have engaged with our Health Board team on this before the decision was communicated. That would be in keeping with their usual working arrangements during the pandemic.

99. In my view the following were key decisions taken by WG in respect of care homes. I do not believe I was personally involved in providing views to support these decisions but I would expect that WG officials would have discussed these before guidance was issued with the relevant members of my senior team.

    a. 7 April 2020: WG expanded the remit of high priority key workers eligible for Covid-19 testing to include are home staff;
    b. 3 May 2020: Testing for enclosed care settings that have an ongoing outbreak which commenced before 2 May 2020;
    c. 16 May 2020: Offering testing to all staff and residents within settings that have not reported an outbreak or any cases within the last 28 days (either via the ABUHB COVID-19 Testing Unit or the Welsh Government Social Care Portal);

d. 20 May 2020: Offering testing to settings that are already in an existing or new outbreak; larger settings that are registered as having 50 or more occupied beds;
e. 5 June 2020: The Chief Medical Officer issued a letter offering care staff working in enclosed care settings to engage in weekly asymptomatic testing, for a four-week period (pilot extended to 27.9.20).

B.7. Impact on Hospitals

100. I think the key decisions made by WG that impacted on health systems were:
a. 13 March 2020: Stopping all planned elective work and not bringing patients into hospital unless it was absolutely necessary;
b. Discharging all patients who no longer required hospital care, including discharging patients to care homes; and
c. Control of infection guidance, as we were trying to keep patients away from other patients.
d. Hospital visiting guidance, which was published on 25 March 2020 and updated regularly throughout the pandemic.
e. Shielding;
f. Funding of NHS services;
g. Lockdowns/Local Restrictions.

101. I cannot recall any decisions made by WG that impacted on hospitals as regards the use of DNAR orders. However, in response to concerns raised by groups advocating for disabled and learning disability communities in Wales about how the Clinical Frailty Scale (CFS) could be used inappropriately in making decisions on escalation of care and "do not attempt cardiopulmonary resuscitation" (DNACPR) for individuals being treated for Covid 19, I received a joint letter from the CMO and CNO regarding the use of DNAR orders The letter was sent to ensure clarity around ethical decision making for people with any protected characteristics and reminded all healthcare providers that:
a. age, disability or long term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes;
b. it remains essential that decisions are made on an individual and consultative basis with people according to need and individual wishes; and

c. it is unacceptable for advance care plans, with or without DNACPR form completion to be applied to groups of people of any description.

102. In order to manage hospital capacity and reduce in-person contact, as set out above, in early March 2020 ABUHB introduced "Attend Anywhere" a platform which provided clinicians with the facility to conduct a medical consultation with patients remotely using video. This was funded by WG and was rolled out nationally.

103. The Chief Executive of NHS Wales and NHS bodies across Wales work closely and there was lots of contact on a regular basis. During the pandemic, there was a constant flow of information between ABUHB (and all Welsh NHS bodies) and WG through the meetings that I attended with Andrew Goodall and through meetings between ABUHB's Director of Public Health and the CMO. As far as I can recall, all of the decisions made by WG that impacted on hospitals were initially discussed at these meetings and WG would take views from the NHS, consider those views and at some point, whatever decision had been taken by WG would be communicated by email or letter. It was rare for a decision that impacted hospitals or the broader NHS to come out cold without the Heath Board's prior knowledge. Issues were discussed, possible solutions developed together and then a decision was made by WG.

104. I felt like WG and all NHS Wales bodies, including ABUHB, and all the broader public service organisations were working together during the pandemic to understand the virus, manage patient care, support communities and staff and keep them safe. As a Health Board we were sharing information with WG as to what was happening on the ground – the reality of it – and WG was sharing its understanding from the scientific community; what they were hearing and testing out.

105. I cannot think of many instances when a proposal was raised for discussion and I directly advised WG not to proceed with their plans. I mentioned my view on the siting of community testing centres on acute hospital sites earlier in my statement and this did not happen in our area. I recognised that WG had access to all sorts of scientific and other UK advice through the UKG and national bodies. In some

ways it was more about WG informing ABUHB and other NHS bodies what needed to happen and why, and us telling WG how we would manage and implement that and by when. It was more of a codesigned process in which ABUHB could raise any particular concerns or issues in response to WG proposals, and also suggest how these could be overcome operationally. My overriding reflection is of good cooperation and where WG or any public body didn't know the answer we used our best endeavours and judgment to do the right thing.

B.8. Test, Trace and Protect

106. In Wales there was a national Test, Trace and Protect ("TTP") Programme. Welsh Government launched their Test ,Trace and Protect Strategy on 13th May 2020. This was a collaboration between WG, Public Health Wales, NHS Wales and local authorities to contain the spread of Covid 19. The TTP programme provided the foundation to establish an effective and robust contact tracing service in Wales. A national Programme Board was put in place by WG to provide oversight of the TTP Programme and with local delivery through a collaborative endeavour between each Health Board, PHW and their respective local authorities.

107. I recall extensive conversations between WG, PHW, the Health Boards and Local Government about the operational delivery, workforce arrangements and cost. ABUHB had five local authorities in our area which added a layer of complexity but working in collaboration, a system was agreed with the 5 Local Authorities to deliver the Testing and Tracing model to our population of circa 600,000 people. ABUHB working with its 5 local authority partners and PHW developed the Gwent Test Trace and Protect Service which went live on 1 June 2020.

108. Save for some negotiation over funding for contact tracing, I am not aware of any difficulties encountered by ABUHB directly relating to WG decisions in respect of Test, Trace and Protect. I do not recall any issues with access to testing capacity which was organised by ABUHB with fixed, mobile and 'pop up' testing as needed. Neither do I recall any specific issues with contract tracing in our area, which was established as part of the Gwent TTP service.

109. I believe the TTP Programme in Wales was successful in its planning and deployment due to the collaboration between public sector partners and Welsh Government.

PART C

My role as Chief Executive of the NHS in Wales and Director General of the Health and Social Services Group

110. The Chief Executive of the NHS in Wales ("CEO NHS Wales") and Director General Health and Social Services ("DG HSS") brings together the responsibilities of a Director General in the Welsh Government alongside the system leadership and oversight of NHS in Wales. A copy of the Candidate Brief and Job Description is attached in exhibit **JPM2BWG01/02-INQ000239578**. I am appointed by the Permanent Secretary as the additional accounting officer for the NHS, supporting the Permanent Secretary in his role as the Principal Accounting Officer for the Welsh Government. As such, I am responsible for providing effective support to ministers, coordinate development of health and care policy, enable collaboration across public services and ensure the delivery of high-quality health and health care services to the Welsh population.

111. In this role I report directly to the Permanent Secretary, Andrew Goodall and I am part of the senior leadership team for the Welsh Government, as well as leading my own department of professionals and specialists providing leadership to the health and social care sectors in Wales.

112. As DG HSS I am the principal adviser to the Minister for Health and Social Services, the Deputy Minister for Social Services and the Deputy Minister for Mental Health and Well-being, as well as to the First Minister and the Cabinet on all NHS and Social Services policy matters. This role does not require any direct contact with representatives from the governments of England, Wales or Scotland, though there will be those within my team who did have contact with counterparts in the other four nations during the pandemic.

113. The CEO NHS Wales role involves the leadership and oversight of appropriate planning, delivery and assurance across NHS Wales, working with all NHS organisations. There is a particular focus on prevention, integration, new service models and the quality and safety of services that is set out within "A Healthier Wales" as the extant long-term plan for the health and care system in Wales. A copy of this plan is exhibited in **JPM2BWG01/03-INQ000066130.** This role is Wales-specific and does not require contact with NHS representatives from England, Wales or Northern Ireland.

My role during the pandemic and key decisions

114. By the time I took up my role in the Welsh Government on 1 November 2021 the HSSG had already developed an effective and collaborative approach to its response to the pandemic. I was particularly struck by the commitment and resilience of the teams across the HSSG, recognising that some teams had been responding to the pandemic for two years.

115. Many of the key decisions had already been made, for example I was not involved in the preparation of or advising upon Covid-19 legislation or regulations. Save for the advising on the position of the NHS in respect of the 21-day review of the Coronavirus Restriction Regulations and decisions and actions taken in response to the emergence of the Omicron variant at the end of November 2021. I was not part of the Welsh Government decisions on non-pharmaceutical interventions.

116. I was nonetheless joining at a uniquely challenging time, and this was emphasized by the advent of the Omicron variant during my first month. In a letter to Andrew Goodall on the 6 May 2022 I summarised the response of the HSSG and NHS in Wales to Covid-19 for the period from which I took up the post in November 2021 to March 2022. A copy of this letter is exhibited in **JPM2BWG01/04-INQ000083235** and summaries the work my official and the NHS were undertaking during this period and my oversight of this.

117. As significant part of the role is providing leadership to the NHS in Wales and ensuring the HSSG role in supporting the Ministerial commitments and priorities. The two come together well with the HSSG ensuring that the NHS is supported

and has the necessary information and infrastructure to deliver for the population of Wales.

118. In exhibit **JPM2BWG01/05-INQ000239589** I have set out a summary of my all letters to the Chief Executives of the NHS organisations in Wales collectively during the pandemic period when I was in the role of DG HSS and CEO NHS Wales. These letters, I feel, provide a good summary of the key decision I made during this period and the leadership provided to the NHS and I have summarised and exhibited those specifically relating to the Covid-19 response below.

119. The work that went behind these letters was driven by members of the of HSSG and I would work closely with a number of key officials to support the infrastructure needed to ensure the was supported NHS to deliver on what I was asking them to do in these letters. Often these letters would also have been preceded with discussions with NHS organisations as well. The letters are essentially the outcome of significant work and discussions that were taking place.

120. In relation to the Covid-19 response, my immediate action was to secure additional resources to support the Covid-19 vaccination programme and I wrote out to the NHS to confirm this on 30 November 2021. A copy of this letter is exhibited in **JPM2BWG01/06-INQ000239576.**

121. On the 6 December 2021 I wrote out to the NHS to highlight system pressures, confirm priorities and the contingency plans that needed to be developed in light of the emergence of Omicron. A copy of this letter is exhibited in **JPM2BWG01/07-INQ000239566.** Shortly after this, on the 14 December 2021, I wrote to ask all the Health Boards to provide me with information on their ability to stand up field hospitals if required. A copy of this letter is exhibited in **JPM2BWG01/08-INQ000239590.**

122. On the 16 December 2021 I requested weekly reporting from the health boards to enable me to assess the system resilience and local option available. A copy of this letter is exhibited in **JPM2BWG01/09-INQ000239591.** I followed this up with a further letter on the 17 December 2020 outlining the reprioritisation of NHS services. A copy of this letter is exhibited in **JPM2BWG01/10-INQ000239574.** This information was important to ensure that Ministers could consider the capacity of

and headroom in the NHS in making decisions in respect of the imposition or non-imposition of NPIs during this period and in response to the Omicron variant.

123. In light of pressures of the Omicron virus we also had to consider the business-as-usual delivery and the impact Omicron could have on that. On the 21 December 2021 I wrote out to the NHS Chief Executives to confirm that the planned submission date for the Integrated Medium Term Plans would be shifted to account for the pressures currently being faced. A copy of this letter is exhibited in **JPM2BWG01/11-INQ000239592.**

124. After Christmas 2021 things started to settle. I wrote out to the NHS on the supply and use of respiratory protective equipment on the 1 February 2022, outlining adherence to the UK guidance was to continue. A copy of this letter is exhibited in **JPM2BWG01/12-INQ000239592.** This was reiterated on the 10 February 2022 where I noted the expectation that IPC Guidance continued as we moved to a business-as-usual arrangement, and that organisations embed the best practices / measures put in place during the pandemic as we transitioned back. A copy of this letter is exhibited in **JPM2BWG01/13-INQ000239593.** I also wrote out on the Vaccination Programme in Wales on the 14 and 21 February 2022, and a copy of these letters are exhibited in **JPM2BWG01/14-INQ000239568** and **JPM2BWG01/15-INQ000239570.**

125. Covid-19 remained a factor that was considered in my direction to the NHS but after this time we were able to move to more business-as-usual matters. This include re-visting the development of the NHS Executive in Wales. The Parliamentary Review of Health and Social Care in Wales, January 2018, reflecting on the earlier OECD Review of Health Care Quality 2016, recommended that the national executive function in NHS Wales be strengthened to develop a more strategic and coordinated set of incentives for Health Boards. This would provide a clearer distinction between the national executive function strategically developing and managing the NHS, and the national civil service function to support delivery of the NHS and Social Care priorities as set by Welsh Government Ministers. The Welsh Government's Response, A Healthier Wales, outlined plans for an NHS Executive function.

126. 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.

127. In Spring 2022 I re-energised this plan. 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 functions in the NHS. The first phase of the work to establish the NHS Executive was completed in 2022/23 and it was launched on 1 April 2023. It brought together the following functions :
    a. NHS Wales Health Collaborative.
    b. NHS Wales Finance Delivery Unit.
    c. NHS Wales Delivery Unit.
    d. NHS Wales Improvement Cymru.

128. Phase 2 of the development work is underway and will further strengthen the capacity and capability of the NHS Executive and this work is planned to conclude in Spring 2024.

129. 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.

Engagement within the Welsh Government and with key individuals

130. Listed below are the key individuals within the Welsh Government with whom I had contact during the pandemic and with whom I worked closely. I had good working relationships with all of those listed below. I never had concerns about access to advice or the timeliness or quality of the advice. During periods of annual leave there was suitable cover available.

<u>My Department</u>

131. Attached to this statement is an organogram of my line management as of 21 November 2021 and as amended in June 2022, exhibit **JPM2BWG01/16-INQ000239596** refers.

132. Of those shown as reporting directly to me I would have regular contact with them, often weekly, through team meetings. I did not use WhatsApp or informal communications. I would communicate with my team and with others predominantly through phone calls, emails, and Microsoft Teams.

133. In terms of providing formal advice to Ministers, as DG HSS I was sighted on Ministerial Advice (MA) submitted by those in my line management structure. A MA document is a document submitted to relevant Ministers for the purpose of providing them with information advice and options, to enable them to make a Ministerial decision. A senior civil servant of at least Deputy Director grade is required to clear all MAs before they are sent to Private Office for Ministerial consideration. The Directors and Deputy Directors would routinely clear the MAs to the Minister for Health and Social Services, but I would be a copy recipient. A list of MAs submitted during the pandemic period and while I was DG HSS is provided in exhibit **JPM2BWG01/17-INQ000239594.**

134. The MA process also provides a channel for Ministers to make decisions relevant to their portfolio which do not require a Cabinet collective discussion or decision. The Welsh Government Cabinet is the central decision-making body of the Welsh Government. The Cabinet business consists, in the main, of matters which significantly engage the collective responsibility of the Welsh Government, either because they raise significant issues of policy or because they are of critical importance to the public. The final decision as to whether an item should be discussed at Cabinet is made by the First Minister. Cabinet papers are commissioned by Cabinet Secretariat from the relevant Welsh Government policy lead. Cabinet papers require the clearance of the Director General of the relevant Group, before being submitted for formal approval to the Minister(s) with portfolio responsibility for the matters which Cabinet is being asked to consider, and to the First Minister. All other Ministers are copied into the submission of the Cabinet paper, along with a centrally prescribed list of officials and Special Advisers. Once

formal approval is received from the portfolio minister and the First Minister, the final papers are circulated by Cabinet Secretariat to all Cabinet members.

First Minister

135. I do not provide formal advice or written advice to the First Minister or to the Welsh Ministers other than the Minister for Health and Social Services.

136. Throughout the Covid-19 pandemic I received a daily update on NHS capacity, the number of Covid-19 related patients (whether testing positive, recovering or suspected) and non-Covid-19 patients in NHS Wales hospitals. That information was summarised and fed into my briefings to the First Minister and others. After June 2022 this was produced three times a week. An example of the daily update received on 30 November 2020 is exhibited in **JPM2BWG01/18-INQ000239561.**

137. I met regularly with the First Minister (see below). During the 'First Minister Update Meeting' I provided Updated Management Information to the First Ministers Office. An email setting out the Covid-19 position in numbers was sent to the First Minister using some of the information received from the daily update (as exhited above). As an example I have exhibited the update to the First Minister dated 1 December 2021 in **JPM2BWG01/19-INQ000239563**. This information included:
    a. The total number of Covid-19 related patients in hospital beds;
    b. The number of confirmed Covid-19 patients in hospital occupying a bed;
    c. The number of Covid-19 related patients in critical care;
    d. Positivity rate
    e. Rate per 100,000
    f. Number of new Covid cases
    g. Number of new Covid deaths
    h. Vaccination – 1st dose, 2nd dose, 3rd dose, booster and % of young people receiving 1st and 2nd doses (12 to 15 year old, 16 & 17 year old and 18 to 29 year old).

138. Copies of the available management information emailed to the Minister will be disclosed to the Inquiry to cover the period from which I came into post on 1 November 2021 and 30 May 2022. Where I did provide advice or my opinion during

meetings with the First Minister, I do not recall any occasion on which that was not followed or acted upon by the First Minister or other Welsh Ministers.

Minister for Health and Social Services

139. I meet with Eluned Morgan, Minister of Health and Social Services on a regular basis informally to provide an update on the HSSG and NHS in general. These meetings are not minuted but I would leave with action points which I would then assign to members of the HSSG to take forward. The topics covered vary and cover correspondence received from the public or Senedd members, issues noted in the media, NHS workforce, any visit or stakeholder meetings the Minister for Health and Social Services, has coming up. This meeting is a touch point and opportunity for the Minister for Health and Social Services to raise points for clarification and for informal updates or 'heads-up' on formal MAs or policies in development.

Permanent Secretary to the Welsh Government

140. As stated above I report directly to the Permanent Secretary, Andrew Goodall. During the pandemic I met with him every week to discuss operational issues related to the HSSG and the management of the NHS. This again is an informal but important touch point. As Permanent Secretary, Andrew is the principal advisor to the First Minister and Cabinet and the Welsh Government's Principal Accounting Officer. In my role Chief Executive NHS I am also designated by the Permanent Secretary as the "Accounting Officer for NHS Wales" and need to provide assurance to Andrew on a regular basis as part of that position as well as DG HSS.

Others

141. My work on the response to the Covid 19 pandemic required more regular contact with the following individuals, outside of the normal line management role I had for those at Director level:

    a. Sir Frank Atherton, Chief Medical Officer to ensure I had the most up to date picture on the public health situation in Wales and information or intel on any variants of concern or changes to CMO UK Alerts which could impact the NHS. CMO would also often provide to Cabinet verbal updates

which reflected the position in the NHS and I would discuss this with him and ensure that he had the necessary information from my officials.

b. Dr Rob Orford, Chief Scientific Adviser for Health- to ensure that any modelling information for the NHS was updated and any advice coming from SAGE was noted as soon as possible.

c. JoAnne Daniels, Director Test Trace Protect (TTP)- TTP was operating in close collaboration with PHW. Understanding the trends coming out of contact tracing data and infection rates was important to map the impact of Covid-19 on NHS capacity.

d. Andrew Sallows, National Director, Planned Care Improvement and Transformation led on interpreting the modelling from SAGE and information from the TTP team to assess NHS capacity.

e. Dr Chris Jones, Deputy Chief Medical Officer, led on infection prevention control issues and was chair of the Nosocomial Transmission Group so I would touch base with him frequently to ensure advice and information was shared with the NHS Executives and NHS organisations.

f. Claire Rowlands, Interim Director of Vaccines to check on the progress of the vaccine programme and ensure NHS organisation were sighted on changes and that any other challenges and pressures were factored into delivery of this significant and important workstream.

g. Helen Arthur, Director of Workforce and Corporate Business- the impact of isolation requirements and vaccination on the NHS workforce was closely monitored by Helen and significant in assessing NHS capacity, pressures and demands.

h. Reg Kilpatrick, Director General Covid 19 – Reg was leading the cross government response to Covid-19 so he would informally update me on the response across government and I would likewise ensure he had the headline points coming out of the NHS and HSSG.

Regular meetings

142. There was a regular pattern to the Welsh Government meetings that occurred during the Covid-19 pandemic. I have had the opportunity to review my electronic calendar from 1 November 2021 – 31 March 2022. I have extracted from that

calendar the meetings or events that related to the Covid-19 pandemic and a copy of that extract is provided as exhibit **JPM2BWG01/20-INQ000239597.**

143. Depending on my availability, I would generally attend the following key groups and meetings:

Weekly

Executive Committee (ExCo)

144. As DG HSSG I am a member of ExCo and attend the weekly meetings chaired by the Permanent Secretary which act as the operational and decision-making forum that supports the Permanent Secretary as the Principal Policy Adviser to the First Minister. The ExCo Terms of Reference are exhibited in **JPM2BWG01/21-INQ000239485.** I would consider this to be the main decision-making meeting that I am engaged in on behalf of the Welsh Government as this operates at a Director General level and focused on the operational delivery of the Welsh Government's priorities across all the portfolios.

HSSG Executive Director Team (EDT) Contingency Group

145. The EDT Contingency Group was set up in late 2020 to provide a more focused oversight of the risks and issues arising from the Covid-19 pandemic, whilst recognising and addressing the concurrent risks arising from the EU Exit and the pressures on the health and social care systems. TAC reported into the EDT Contingencies Group to ensure the Group had full oversight and accountability across all aspects of the HSSG Covid response. The EDT Contingency Group Terms of Reference are exhibited in **JPM2BWG01/22-INQ000231290.**

146. By the time I assumed by role as DG HSSG this group primarily focused on issued relating to Covid-19. I chair the Group's fortnightly meetings. I attach, as a sample, the minutes of an EDT Contingencies Group meeting dated 5 January 2022 in exhibit **JPM2BWG01/23-INQ000239573.**

First Minister ministerial call

147. The First Minister has/had an hour-long call with ministers once a week. It is informal. I attend by phone to listen but do not contribute.

First Minister weekly update meeting

148. The First Minister met weekly with the CMO and I together with key officials from the HSS Group to be updated on all aspects of the Covid19 situation and outlook. This meeting was often attended by the Minister for Health and Social Services and provided an opportunity for discussion and to answer questions from the FM/MHSS on all aspects of the current situation, response and outlook including the impact on NHS services. This meeting was paused on the 25 April 2022 with an agreement that it could be reinstated by the FM or officials at any time if required. There were no formal papers produced for this meeting.

Monthly

NHS Wales Leadership Board meetings

149. I chair the monthly meetings in my capacity as Chief Executive NHS Wales. Meetings are attended by the respective individual Chief Executives for the NHS bodies in Wales. Prior to June 2021 they were known as the NHS Executive Board.

150. These meetings ensure regular and effective two-way communication between the Welsh Government and NHS bodies in Wales. I attach an example of the minutes of one such meeting in exhibit **JPM2BWG01/24-INQ000239595**.

Welsh Government Board meetings

151. The Welsh Government Board provides strategic advice, challenge and assurance to the Permanent Secretary. The Board sits alongside ExCO which is the operational and strategic decision-making forum. The Board meets every six weeks. A copy of the minutes for the first meeting I attended is exhibited in **JPM2BWG01/25-INQ000239575.**

152. At these meetings I would, on occasion, provide a verbal update of the issues facing the NHS at that time. In preparing that update I would rely upon the information provided to me from the key individuals outlined above in paragraph 138. So, in respect of Covid-19 I would summaries the Covid-19 numbers in Wales, position in hospitals, intensive care and vaccination and booster programmes.

Cabinet

153. The Welsh Government Cabinet is the central decision-making body of the Welsh Government. Under normal circumstances, Cabinet meets once per week during the periods when the Senedd is sitting. During the pandemic, meetings were more frequent to reflect the public health situation and also additionally convened every 21 days to meet the requirements for a review of the Covid-19 restrictions, in accordance with the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020.

154. I attend Cabinet virtually to listen but do not/rarely contribute to the discussions unless asked by ministers to provide advice on a specific issue, such as during the pandemic period, for each 21-day review of the Coronavirus Restriction Regulations as I have outlined below.

Cabinet 21-day review

155. My first attendance at Cabinet in respect of the 21-day reviews was on the 15 November 2021. A copy of the minutes is exhibited in **JPM2BWG01/26-INQ000129994.**

156. I attended again on the 29 November 2021. A copy of the minutes is exhibited in **JPM2BWG01/27- INQ000022558.** The CMO(W) provided advice on Omicron, a new variant of concern which was first reported by South Africa to the WHO the previous week and was now rapidly becoming the most dominant variant in that country. Since then, the variant had been identified in mainland Europe, Scotland, and England, and it was only a matter of time before cases would appear in Wales.

157. Further Cabinet meetings took place during the first week of December 2021 to address the threat of Omicron as well as undertake the statutory 21-day review which was due on 9 December 2021. A copy of the minutes is exhibited in **JPM2BWG01/28-INQ000057922.** Andrew Sallows, as Delivery Programme Director for the NHS, accompanied me and presented data which indicated that those in hospital with Covid-19 continued to fall.

158. Cabinet reconvened on 10 January 2022 for an update across portfolios on the Covid-19 situation. A copy of the minutes is exhibited in **JPM2BWG01/29-INQ000022563.** I outlined that there were 500 more people in hospital beds when compared to the same time the previous year. Of the 8546 patients, 1,030 were COVID-19 related, with 786 confirmed cases. This was an increase of 40% over the previous week. Critical care was in surge capacity, of the 170 patients occupying ICU beds only 42 were coronavirus related. There was still an issue with people acquiring Covid-19 in hospital and there had been an increase in people attending health care settings with other illnesses, who were subsequently being identified as positive for Covid-19. More critical for the NHS were staff absences due to sickness and self-isolation requirements, which were between 8-15%, with nursing and midwifery being the most affected. Absence numbers were expected to increase. Therefore, some appointments and treatments had been postponed and staff were being transferred to work in urgent and emergency services.

159. The formal 21-day review took place on 13 January 2022 and noted that hospital admissions due to COVID-19 were reducing, with 58% of infections now being identified as a coincidental illness, and the number of people in ICU also falling. A copy of the minutes is exhibited in **JPM2BWG01/30-INQ000057924.**

160. The next formal review, on 7 February 2022 continued to show a positive outlook. A copy of the minutes is exhibited in **JPM2BWG01/7- INQ000130031.** I updated on the position in the NHS, outlining that Covid-19 pressures in the NHS was lower than previous waves, with 1,140 patients currently occupying hospital beds, of which there were 531 confirmed cases. The number of incidental cases were increasing, with data suggesting that only 30% of patients required treatment for the virus. The number of Covid-19 related patients in intensive care had reduced to 13, but overall units were very busy with 170 beds occupied. Furthermore, there were 750 more people in hospital than in the same period the previous year. Staff absences across NHS Wales were around 7% and there were similar pressures in the care sector.

161. At the next review which took place on 28 February 2022, Cabinet again noted the improving situation and justification for the continued easing of restrictions, and the

option to allow the Regulations to expire was noted. A copy of the minutes is exhibited in **JPM2BWG01/32- INQ000130041.** As the situation improved Cabinet outlined plans for a 'Transition Plan' to move from Covid-19 as an emergency response to it being dealt with in line with other infectious diseases.

162. A further variant of concern raised alarms at the time of the next review on 21 March 2022. This was a sub-variant of Omicron, BA.2. Case rates were rising again along with ICU admissions and there was a need to pause the review and consider the emerging evidence. Cabinet reconvened a few days later and took the view that while they would not add further restrictions, the Regulations were still required to remain in place. A copy of the minutes is exhibited in **JPM2BWG01/33-INQ000022573.**

163. On 12 April 2022, Cabinet met once more at which point Covid-19 was still prevalent across Wales and the wider UK and continued to cause pressure on the NHS; however admissions had now plateaued to around 40 per day. A copy of the minutes is exhibited in **JPM2BWG01/34- INQ000022576.** The latest modelling from Swansea University indicated that medium term projections from 1 April suggested a less challenging scenario, with up to 1,700 beds occupied by COVID-19 patients, compared with around 2,500 projected the previous week. While the legal requirement for face masks in health and social care settings was retained, the remaining restrictions, including requirements on business to take reasonable measures, were lifted.

164. On 23 May 2022 Cabinet met for what would be the final 21-day review. A copy of the minutes is exhibited in **JPM2BWG01/35-INQ000022580.** Infection rates driven by Omicron had started to wane and the situation in the NHS was stabilising. The decision was taken at this review that the legal basis for the Regulations, as a response to a public health threat, was no longer justified. It was however agreed that the Welsh Covid-19 Guidance should continue to advise the use of face-masks in health and care settings. The Regulations therefore expired on 30 May 2022.

<u>Meeting as required</u>

HSSG committee sessions at Senedd

165. I attended the following Senedd Committees on the dates set out below:

a. Public accounts and public administration committee on 17 November 2021 to address COVID-19 and its impact on matters relating to Public Accounts Committee remit, a copy of the transcript of this meeting is exhibited in **JPM2BWG01/36- INQ000182556.**

b. Committee for the scrutiny of the first minister 16 December 2021 to support the First Minister on the COVID-19 recovery and winter pressures on public services, a copy of the transcript of this meeting is exhibited in **JPM2BWG01/37- INQ000088009.**

c. Health and social care committee 13 January 2022 to address NHS Recovery, a copy of the transcript of this meeting is exhibited in **JPM2BWG01/38- INQ000088011.**

d. Children,Young people and Education committee 13 January 2022 to discuss the draft budget a copy of the transcript of this meeting is exhibited in **JPM2BWG01/39- INQ000088010.**

e. Health and social care committee 10 February 2022 to address impact of waiting times and scrutiny of the Welsh government's health and social care winter plan, a copy of the transcript of this meeting is exhibited in **JPM2BWG01/40- INQ000088012.**

166. In addition to the above, I also attend the Senedd with the MHSS to support informal meetings with Committee members as and when required.

TAG/TAC Steering Group

167. The Steering Group steered the work of TAC and TAG to ensure that it met the requirements of the Welsh Government and Welsh Ministers to support the evolving response to Covid-19 from pandemic to endemic in Wales and set this in the context of the work of the Covid-19 Evidence Centre, Welsh Government's Knowledge and Analytical Services and other relevant four nations bodies. The

TAG/Tac Steering Group Terms of Reference are exhibited in **JPM2BWG01/41-INQ000239548.**

168. After I joined the meetings were held monthly until January 2022, thereafter every two months. In advance of the meetings, I would receive the latest modelling, official statistics. I would also receive the current work program so that the priorities could be considered.

169. I did not play any role in the BAME Covid-19 Scientific sub-group and did not attend their meetings.

Lessons learned

170. As outlined above in Part B, paragraph 39 I consider the Welsh Government took appropriate steps to respond to threat of Covid-19. As noted in this statement, for the majority of the early pandemic period I was working outside the Welsh Government. As indicated, there was regular contact between NHS bodies and WG during the period covered by this statement with good sharing of scientific and operational data.

171. Initially, I felt that modelling information provided by the Welsh Government to me, as a key decision maker for ABUHB, was not helping with the immediate decisions that needed to be made particularly around NHS bed capacity. As time went on this improved. Since joining the Welsh Government, I feel adequately supported in terms of data and advice.

172. Part of the reason the provision of data and information improved was the close working relationship that developed between the Welsh Government and NHS bodies. I believe this was a key area which worked well.

173. The relationship that existed before the pandemic was enhanced during this period particularly during the thrice weekly calls between all the CEOs and Andrew Goodall and other HSSG officials which enabled communication in a more informal way rather than agenda-based discussions. This allowed for information to be shared quickly and issues to be addressed at pace. I provide an example of this in

Part B in respect of ventilators which is a good example of not only co-operation with the Welsh Government but across LHB boundaries in the strategy and planning of resources.

174. That positive collaboration extended to the engagement of other public services (e.g. Police, Local Government, third sector, Fire and Rescue Services, etc.) at a Wales and LHB level. Our history of working in social partnership Wales also supported effective working relationships and communication with staff side representatives and Trades Unions.

175. The Welsh Government provided clarity on what was required and why and NHS bodies worked together and with local partners to operationalise the response required, e.g., community testing, tracing services, vaccination. Communication was frequent and supportive.

176. There was an active multiagency health protection network prior to the pandemic that could be built upon to provide good situational awareness and understanding for all relevant parts of the system.

177. Within the ABUHB, the decision-making structures introduced by the Health Board were effective in supporting the agile response required to the Covid-19 pandemic. Effective governance and decision making was maintained despite the need to work at pace. The communication and working relationship between the Health Board and the Welsh Government was constructive and based on collaboration. The Health Board was provided with the financial resources needed to support its pandemic response.

178. In terms of areas to improve on or missed opportunities, I have reflected on this for the purpose of this statement. I am aware of and sighted on the lesson learned exercises within the Welsh Government but here I have focused on my personal views based on my experience.

179. I consider the restriction placed on the testing criteria at the end February/ early March 2020 meant there was a missed the opportunity to identify Covid-19 positive patients in our hospitals. My experience in ABUHB would suggest that Covid-19 was circulating in our community before March 2020 when our first case was

identified. Earlier testing of symptomatic patients in hospital or the community without a relevant travel history would, I feel, highlighted the community transmission rates sooner to enable earlier action to control the incident and spread of the virus.

180. In terms of understanding the international response to Covid-19, I had no direct role in this. My understanding is that the TAG and TAC were linked into the international position as were PHW.

181. Since taking up my role in the Welsh Government on 1st November 2021, I have been able to witness how the HSSG and NHS Wales has worked together over recent years prior to the pandemic to develop an effective public health infrastructure based on local knowledge and expertise. More recently the CMO commissioned an independent review of our health protection system – this was published in February 2023 alongside and action plan to deliver the recommendations. A copy of the report is exhibited in **JPM2BWG01/42-INQ000177516.**

182. Within the Welsh Government HSSG took a continuous review and active learning approach to the pandemic response. As an example, two reviews were undertaken to consider the HSSG response and to use learning to strengthen the HSSG covid response in the immediate term and inform emergency planning arrangements more generally for the future.

183. The first of two reviews, exhibited in **JPM2BWG01/43- INQ000022615** focussed on the period January 2020 – September 2020 and was presented in September 2020. The scope of the first review looked to identify learning from January to September 2020 in order to consider how we might approach further phases of Covid-19 (including concurrence with other incidents through winter).

184. The following key themes and findings were detailed in the report:

a) Incident response

b) Policy development and delivery

c) Communications

d) Governance and accountability

e) People, skills and wellbeing

f) Positive outcomes

185. Within these themes, areas of good practice were identified as well as areas and recommendations for improvement.

186. In June 2021, the HSSG EDT Contingency Group agreed that there should be a second review of HSSG COVID response to follow on from a review of its response to COVID that covered the period July 2020 -June 2021. A copy of this review is exhibited in **JPM2BWG01/44- INQ000066470.** The main focus was how to improve co-ordination of response and decision making, approach to future waves of covid and approach to future pandemics and national emergencies.

187. As well as highlighting good practice, the review responses also identified areas that require strengthening. The following key themes and findings were drawn out from the responses and both good practice and areas for improvement were grouped under the following headings:

a) Decision Making

b) Governance and Accountability

c) Contingency Planning

d) People and Skills

e) Communications and Engagement

f) Outcomes

188. While these reports preceded my appointment, since coming into post, I have received updates on the development and implementation of the recommendations and oversaw these through updates given to EDT Contingency Group, with one being held in October 2022. I also held conversations on the

development of the strategic recommendations to ensure an overall system fit and alignment.

189. We have reviewed the Covid response structure and implemented changes. The EDT Contingency Group introduced during the pandemic is now established as our 'Business As Usual' working arrangements to retain the focus on emergency risk and planning. Based on our pandemic experience the HSSG structure has been strengthened to include a Director for Health Protection and a Director for Health and Wellbeing working alongside the CMO. The Directorate of Health Protection has capacity and resource allocated to the following functions:

    a. Science Evidence and Advice

    b. Health Protection Policy and Priority Programmes

    c. System Oversight and Response

    d. Vaccination.

190. The Communicable Disease Outbreak Plan was updated in 2022 to reflect learning and will be subject to a full review in 2023

191. In relation to immunisation and its important role in both prevention and response to serious disease and we have taken the learning from our Covid-19 vaccination programme to our other immunisation programmes. This resulted in the Winter Respiratory Vaccination Strategy for 2021 which integrated the COVID-19 and influenza vaccination programmes. This was the first step in our vaccination transformation journey, and we launched the National Immunisation Framework in 25 October 2022 setting out our ambitions for continued vaccination transformation, with a deepening of integration, to improve service provision for everyone in Wales.

192. There are still lessons to be learned and we are grateful for the Inquiry's interest in the learning from the pandemic period.

Statement of Truth

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

Signed: Personal Data

Dated: 03/01/2024