Witness Name: Andrew Goodall
Statement No: M5 1
Exhibits: 51
Dated: 17 January 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ANDREW GOODALL

I provide this first statement for Module 5 in response to a request under Rule 9 of the Inquiry Rules 2006 dated 9 October 2024 issued under reference M5/Goodall/01.

Preface

1. The purpose of this statement is to assist the work of the UK Covid-19 Public Inquiry. My statement will address the procurement and distribution of key healthcare related equipment and supplies in relation to the Covid-19 pandemic from 1 January 2020 to 28 June 2022 ("the relevant period"), so that lessons can be learned, and recommendations made for the future.

Professional background and experience

2. I have a law degree from Essex University and a PhD in Health Service Management from Cardiff Business School, Cardiff University.

3. I was appointed to the role of the Welsh Government's Permanent Secretary in September 2021 and took up the role in November 2021. I lead the Welsh Government Civil Service in delivering the priorities of the First Minister and her ministerial team. I am the Welsh Government's Principal Accounting Officer and principal advisor to the First Minister and Cabinet. I should emphasise this is a unified and integrated government, rather than a department. Accordingly, I am responsible for organising civil service support to ministers across a wide range of policy, legislative and administrative areas. An equivalent range of responsibilities would be discharged by several Permanent Secretaries at UK Government level.

4. Prior to this, I was the Director General of Health and Social Services and Chief Executive NHS Wales, a position that I had held since June 2014.

5. Before being appointed as the Director General, I was the Chief Executive of Aneurin Bevan University Health Board, a position that I held from the Health Board's inception in October 2009 until 2014.

Introductory

6. I have been asked to provide a statement to assist the Inquiry to understand the role of the Chief Executive of the NHS in Wales and that of the NHS in Wales as relevant to the scope of Module 5 to the Inquiry. Module 5 examines the procurement and distribution of key healthcare equipment and supplies, including personal protective equipment ("PPE"), ventilators and oxygen, lateral flow tests and polymerase chain reaction ("PCR") tests, all of which were used in response to Covid-19.

7. I understand that Alan Brace, who was the Health and Social Service Group's Director of Finance up to June 2021, has provided a corporate statement outlining the role of the Health and Social Services Group during the relevant period and in the scope of Module 5 (reference **M5-WGHSSG-01**). That statement sets out the work of that Group in detail which, as Director General, I had oversight of and worked with Alan Brace in this regard. That statement also sets out Alan Brace's role during the pandemic, which included providing executive leadership and coordination in relation to PPE in Wales and illustrates that he remained very close to the detail on operational aspects of sourcing, storage and distribution of PPE. I found Alan's role to be extremely helpful and, although I remained ultimately accountable, I relied on him considerably in matters pertaining to PPE within the scope of his role. This meant that, through his clear leadership, I was more effectively able to discharge my duties as Chief Executive of NHS Wales and exercise strategic leadership and management in respect of all areas of the NHS in Wales, including those areas beyond the scope of Module 5.

8. I understand that a statement has also been provided by Andrew Slade, who is now Director General, Economy, Energy and Transport, to address the role of the Commercial and Procurement Directorate (reference **M5-WGCPD-01**) in relation to the Welsh Government's oversight of public procurement, including of PPE and health equipment and supplies. This statement will not reiterate the work of the Health and Social Services Group nor the Commercial and Procurement Directorate but instead focus on the NHS in Wales and my role as the Chief Executive NHS Wales.

Chief Executive NHS Wales

9. The role of Chief Executive NHS Wales is not a statutory role; however, it is a significant and distinctive post located in the Welsh Government, bringing together the responsibilities of the Director General, Health and Social Services in the Welsh Government with the leadership and oversight of the NHS in Wales. I held the positions of Director General Health and Social Services Group and Chief Executive NHS Wales from June 2014 to November 2021 after which I took up the position of Permanent Secretary for the Welsh Government.

10. As Director General Health and Social Services during the pandemic I was responsible for: -

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

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

    c) The availability and use of data and evidence in decision making.

    d) Preparedness, NHS capacity, and the ability to increase capacity and resilience.

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

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

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

    h) Shielding guidance, and the protection of the clinically vulnerable.

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

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

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

l) Supporting the Welsh Government's development of policy for social services and oversight of the care sector, including through my line management of Director of Social Services and Integration/Chief Social Care Officer for Wales.

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

11. The Chief Executive NHS Wales is accountable to the Minister for Health and Social Services for the oversight and performance of the NHS in Wales, and responsible for providing policy advice and exercising strategic leadership and management of the NHS in Wales. As Chief Executive NHS Wales I was also the Accounting Officer for the NHS in Wales, a role designated by the Welsh Government's Permanent Secretary. I will detail this further below, but this role acted as an important lever over the performance and leadership of NHS organisations in Wales as the individual chief executives of these organisations financially reported to myself and I in turn had a responsibility to account for the NHS expenditure. As such, the role aligns closely with that of the Director General Health and Social Services, as the senior civil servant in the Welsh Government's Health and Social Services Group.

12. I was also supported in my role by Simon Dean, Deputy Chief Executive NHS Wales. At the start of the pandemic Simon was on secondment, acting as Interim Chief Executive of Betsi Cadwaladr University Health Board from 10 February 2020 to 31 August 2020, following which he returned and continued in the Deputy Chief Executive position until his retirement on 31 December 2021. From October 2020 Simon was asked to take up a role to act as the NHS bridge leading on PPE, including the connections and oversight with the NHS Wales Shared Services Partnership. A copy of my email updating Ministers of this is exhibited as **M5/AG/001- INQ000513752.** From that date onwards Simon, alongside his broader Deputy Chief Executive role was more involved in the day-to-day liaison with the NHS Wales Shared Services Partnership, which led on procurement for the NHS in Wales. Further information on the role of NHS Wales Shared Services Partnership is detailed below in this statement.

13. To help give an indication of the roles and responsibilities of the Director General, Health and Social Services and Chief Executive NHS Wales beyond the specific context of the

Covid-19 pandemic, I produce here, as exhibit **M5/AG/002-INQ000239578**, a copy of the job description for this role (dated 12 March 2023).

Structure of the NHS in Wales

14. While the term "NHS Wales" is commonly used to refer collectively to local health boards, trusts and special health authorities in Wales, unlike NHS England, there is no central legal entity of this name. NHS Wales is shorthand for "the NHS in Wales" and collectively refers to local health boards, trusts and special health authorities in Wales ("NHS bodies in Wales") and those carrying out NHS functions on their behalf, to provide a range of primary, secondary, and specialist tertiary care services and community services including district nurses, health visitors, midwives, community-based speech therapists, physiotherapists and occupational therapists.

15. Healthcare has been a devolved function since 1999[1]. The NHS in Wales is therefore the responsibility of the Welsh Government. The Welsh Ministers set the high-level policy framework and targets for the health service, which are then delivered by local health boards and NHS trusts in Wales. The full legislative history of the devolution of health in Wales is outside the scope of this Inquiry and statement but the governance and structures of the NHS in Wales may be traced back to the National Health Service Act 1977.

16. The Welsh Ministers (served during the relevant period by the Welsh Government's Health and Social Services Group) are responsible under the NHS (Wales) Act 2006 for the promotion and provision of a comprehensive health service in Wales which includes the provision of hospitals and other services or facilities as required for the diagnosis and treatment of illness. The Welsh Ministers have a broad range of powers that they may exercise in relation to the NHS bodies in Wales; this includes the power to direct local health boards, trusts, and special health authorities in relation to how they exercise their legal responsibilities under the NHS (Wales) Act 2006 or to perform legal responsibilities on the behalf of the Welsh Ministers. The Welsh Ministers have established local health boards which together cover the whole of Wales; and ministers have delegated various functions to each board established, in respect of its own area and particularly in respect of the usual residents in that area. Each local health board is legally responsible for healthcare service in relation to a particular part of Wales. NHS Trusts and special health authorities in Wales are also similarly established under the NHS (Wales) Act 2006 and are directed by the Welsh Ministers to provide specific services on an all-Wales basis.

[1] This function was initially carried out by the National Assembly for Wales until transferred to the Welsh Ministers in 2006.

17. Further information on each of the local health boards, trusts and special health authorities and their legal responsibilities is provided below.

Local Health Boards in Wales

18. In Wales, healthcare services are primarily delivered by local health boards who are responsible for planning, securing and delivering all healthcare services for the benefit of their resident population in a specific geographical area. This includes primary, community, acute and mental health services.

19. The principal functions of local health boards are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511), which are regulations made by the Welsh Ministers in exercise of their powers under section 12 of the NHS (Wales) Act 2006.

20. The Welsh Ministers delegate to local health boards functions under the NHS (Wales) Act 2006 as well as under six other statutes[2]. These functions include the Welsh Ministers' general duty under section 1 of the NHS (Wales) Act 2006 to continue to promote and provide comprehensive health service in Wales. The powers exercised by local health boards pursuant to such delegation (subject to certain exceptions) are in respect of those persons usually resident in the area for which the local health board is established. In addition to those functions delegated by the Welsh Ministers, parts 4 to 7 of the NHS (Wales) Act 2006 impose specific duties on local health boards in relation to the provision of medical and dental services.

21. There are currently seven local health boards in Wales[3]:

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

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

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

[2] See Schedule 1 of Local Health Boards (Directed Functions) (Wales) Regulations 2009/1511
[3] The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009, No. 778 (W.66)

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

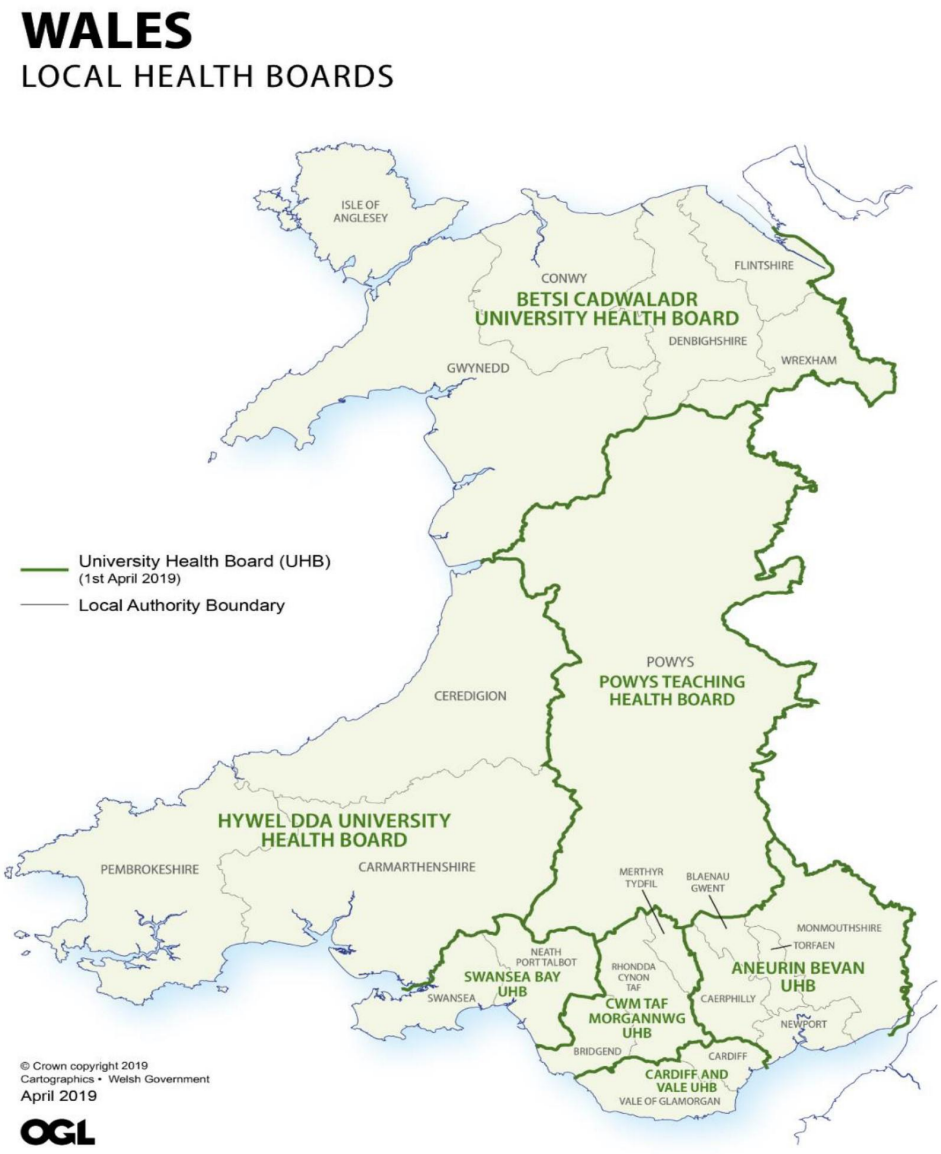
e. Hywel Dda University Local Health Board (covering Carmarthenshire, Pembrokeshire and Ceredigion local authorities)

f. Powys Teaching Local Health Board (covering Powys) (operating as Powys Teaching Health Board)

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

22. A map illustrating the geographical areas of each Local Health Board in Wales is set out below:

Figure 1: Map illustrating the geographical areas of each Local Health Board in Wales



23. A list of the local health board chief executive officers and chairs for the relevant period is provided below:

Table 1: Table listing all the Local Health Board chief officers and chairs between 2020 - 2022

Local Health Board	Current Chair	Chair at start of pandemic	Current Chief Executive	Chief Exec at start of pandemic
Aneurin Bevan University	Ann Lloyd CBE (since June 2017)	Current	Nicola Prygodzicz (since 5 September 2022)	Judith Paget (2014 – 31 October 2021) Glyn Jones *Interim* (1 November 2021 - 4 September 2022)
Betsi Cadwaladr University	Dyfed Edwards (since February 2023)	Mark Polin (2018-2023)	Carol Shillabeer (since 3 May 2023)	Simon Dean *Interim* (Feb 2020 – 31 August 2020) Gill Harris *Interim* (1 Sep 2020 – 31 December 2020) Jo Whitehead (Jan 2021 – November 2022) Gill Harris *Interim* (November 2022 – May 2023)
Cardiff & Vale University	Charles Janczewski (*Interim* since 6 August 2019 appointed Chair June 2020)	Current	Suzanne Rankin (since 1 February 2022)	Professor Stuart Walker *Interim* (1 October 2022 – 31 January 2022) Len Richards (2017 – 30 September 2021)
Cwm Taf Morgannwg University	Jonathan Morgan (since April 2023) Emrys Elias *Interim* (1	Professor Marcus Longley (October 2017 – 30	Paul Mears (since September 2020)	Sharon Hopkins *Interim* (June 2019 – August 2020)

	October 2021-March 2023)	September 2021)		
Hywel Dda University	Dr Neil Rhys Wooding (June 2024) Judith Hardisty *Interim* (October 2023 – May 2024)	Maria Battle (August 2019 – October 2023)	Phil Kloer (February 2024)	Steve Moore (January 2015 – February 2024)
Powys Teaching	Carl Cooper (since October 2022)	Vivienne Harpwood (2014 – 2022)	Hayley Thomas *(Interim* since 3 May 2023, appointed February 2024))	Carol Shillabeer (March 2015 to 1 May 2023)
Swansea Bay University	Jan Williams (1 June 2024) Emma Wollett (April 2020 – 31 May 2024)	Emma Wollett *Interim* (July 2019 – April 2020)	Abigail Harris (Since October 2024) Richard Evans (*Interim* since August 2023-October 2024)	Tracy Myhill (2018 – 31 December 2020) Mark Hackett (1 January 2021 – August 2023)

NHS Trusts in Wales

24. There are three NHS trusts in Wales: Public Health Wales NHS Trust, the Welsh Ambulance Services NHS Trust and Velindre NHS Trust.

25. Public Health Wales NHS Trust (known as "Public Health Wales") was established on 1 October 2009 as a new unified public health organisation[4]. The functions of Public Health Wales are to:

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

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

[4] Public Health Wales National Health Service Trust (Establishment) Order 2009/2058

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

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

26. Public Health Wales is the national public health agency in Wales. One of its roles is to protect the public from infection and to provide advice to the public, the NHS bodies, and the Welsh Government.

27. Since 1 April 2023, Public Health Wales has hosted the NHS Executive which brings together activities and functions that already existed across the NHS in Wales, namely the Delivery Unit, the Finance Delivery Unit, Improvement Cymru and Health Collaborative. The purpose of the NHS Executive is to drive improvements in the quality and safety of care to achieve better, fairer healthcare outcomes for the people of Wales. Underpinned by clinical networks and national programmes as key mechanisms to support improvement, change and delivery, its core functions include:

a. Ensuring that robust assurance processes and mechanisms are in place to hold NHS Wales organisations to account for meeting expectations and outcomes set by the Welsh Government.

b. Ensuring financial sustainability and delivery, alongside maximising the impact and use of health and social care spending in Wales.

c. Delivering ministerial directions and priorities via the National Clinical Framework, supported by strategic clinical and implementation networks and programmes.

d. Translating the policy direction and standards set by Welsh Government into action that improves the quality and safety of healthcare in Wales.

28. The NHS Executive is not a decision-making body, and the legislative framework and the responsibilities of individual NHS organisations are unchanged. The NHS Executive did not play any role in relation to the procurement of PPE or other health equipment or supplies related to the Covid-19 pandemic because it has only been operational since 1 April 2023, however the NHS Finance Unit which forms part of the NHS Executive did have a role to play which is detailed further below.

29. The Welsh Ambulance Services NHS Trust was established pre-devolution on the 1 April 1998[5], with the management of NHS Direct Wales being transferred to the Welsh Ambulance Services NHS Trust in April 2007. The Welsh Ambulance Services NHS Trust, as the sole national provider of 999 Emergency Medical Services in Wales, provides the call handling, clinical assessment and advice functions of the NHS 111 Wales service; and provides a non-emergency patient transport service ("Non-Emergency Patient Transport Service").

30. Velindre University NHS Trust was established on 1 April 1994[6] and at that time was a single speciality trust providing only cancer services. Over the years, the Trust has significantly evolved and expanded. The main function of Velindre University NHS Trust is to provide all-Wales and regional clinical health services to the NHS and the people of Wales. Velindre University NHS Trust consists of two clinical divisions: Velindre Cancer Centre and the Welsh Blood Service. The latter works with its UK counterparts both formally and informally to ensure the safety of the blood supply chain.

31. Velindre University NHS Trust also hosts the NHS Wales Shared Services Partnership, and until 1 April 2021 Velindre hosted the NHS Wales Informatic Services. On 1 April 2021 NHS Wales Informatic Service's functions were transferred to Digital Health and Care Wales, a new special health authority. Hosted organisations have their own Board or committee where more detailed discussions, review and approval of strategy and performance takes place. Velindre University NHS Trust is accountable for the statutory, legal and compliance framework. Further information about the NHS Wales Shared Services Partnership and the NHS Wales Information Services is provided below.

32. A list of the NHS trust chief officers and chairs between 2020 – 2022 is provided below:

Table 2: Table listing all the NHS Trust chief officers and chairs between 2020 - 2022

NHS Wales Trusts	Current Chair	Chair at start of pandemic	Current Chief Executive	Chief Exec at start of pandemic
Public Health Wales	Pippa Britton OBE (from December 2024)	Jan Williams OBE (since September 2017 until 31 May 2024)	Dr Tracey Cooper (since June 2014)	Current

[5] The Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998. S.I. 1998/678
[6] Velindre National Health Service Trust (Establishment) Order 1993/2838 (as amended)

Velindre	Donna Mead (since May 2018)	Current	David Donegan (from December 2024)	Steve Ham (since approx. 2018-December 2024)
Welsh Ambulance Services	Colin Dennis (since October 2022)	Martin Woodford (since 2019)	Jason Killens (since September 2018)	Current

Special Health Authorities in Wales

33. There are two Welsh special health authorities: Health Education and Improvement Wales, and Digital Health and Care Wales.

34. Health Education and Improvement Wales was established in 2018[7] and its functions relate to the planning, commissioning and delivery of education and training for the Welsh health workforce. This was the first Welsh special health authority established by the Welsh Ministers.

35. Digital Health and Care Wales was established in 2020[8] and became operational in 2021. Digital Health and Care Wales has such functions as the Welsh Ministers may direct in connection with the following areas:

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

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

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

    d. Supporting bodies and persons identified in directions given by the Welsh Ministers to Digital Health and Care Wales in relation to matters relevant to digital platforms, systems and services.

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

[7] Health Education and Improvement Wales (Establishment and Constitution) Order 2017/913
[8] Digital Health and Care Wales (Establishment and Membership) Order 2020/1451

36. There are also two joint special health authorities operating on an England and Wales basis: the NHS Business Services Authority and NHS Blood and Transplant.

37. NHS Business Services Authority[9] and NHS Blood and Transplant[10] are established jointly by the Secretary of State and the Welsh Ministers. As these are joint special health authorities the Welsh Ministers may direct the NHS Business Services Authority or NHS Blood and Transplant to exercise any of the functions of the Welsh Ministers relating to the health service in Wales which are specified directions made under the 2006 Act.

38. A list of the Welsh special health authority chief officers and chairs between 2020 – 2022 is provided below:

Table 3: Table listing all the special health authority chief officers and chairs between 2020 - 2022

Special Health Authorities	Current Chair	Chair at start of pandemic	Current Chief Executive	Chief Exec at start of pandemic
Digital Health and Care Wales	Simon Jones (since October 2021)	Bob Hudson 2020 – 2021 (DHCW established in 2021)	Helen Thomas (since 2021)	(DHCW established in 2021)
Health Education & Improvement Wales (HEIW)	Dr Chris Jones CBE (since October 2018)	Current	Alex Howells (since February 2018)	Current

39. The NHS (Wales) Act 2006 provides legislative mechanisms to enable the NHS bodies to work together with other bodies both inside and outside Wales. Local health boards in particular have broad powers to make arrangements with any person or body to provide or assist in providing services under the NHS (Wales) Act 2006;[11] to exercise their functions jointly with a range of bodies including other local health boards, trusts, NHS Commissioning Board or Integrated Care Boards (following the abolition of Clinical Commissioning Groups pursuant to s.14Z27 of the NHS Act 2006)[12] and they may also be directed by the Welsh Ministers for their functions to be exercised by committees or by a special health authority.

[9] The NHS Business Services Authority (Awdurdod Gwasanaethau Busnes y GIG) (Establishment and Constitution) Order 2005

[10] The NHS Blood and Transplant (Gwaed a Thrawsblaniadau'r GIG) (Establishment and Constitution) Order 2005

[11] Section 10 of the NHS (Wales) Act 2006.

[12] Section 13 of the NHS (Wales) Act 2006.

40. One significant way in which NHS bodies in Wales have organised themselves to work together is via a range of committees, partnerships, associations and hosted bodies in place which service the whole of Wales and form part of the NHS in Wales. I have set out below a diagram showing the structure of the NHS organisations in Wales as of 2020 and another as of 1 April 2024 so the changes to the structure may be seen and to assist the Inquiry to have a full picture of the NHS in Wales:

Figure 2: Diagram showing the structure of NHS organisations in Wales as of 2020

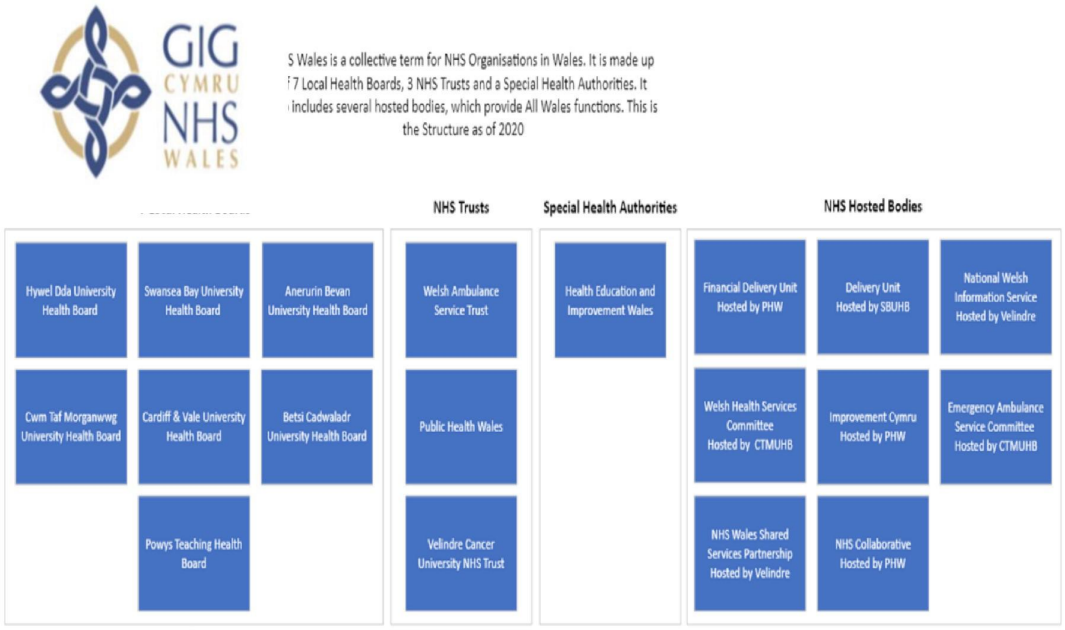
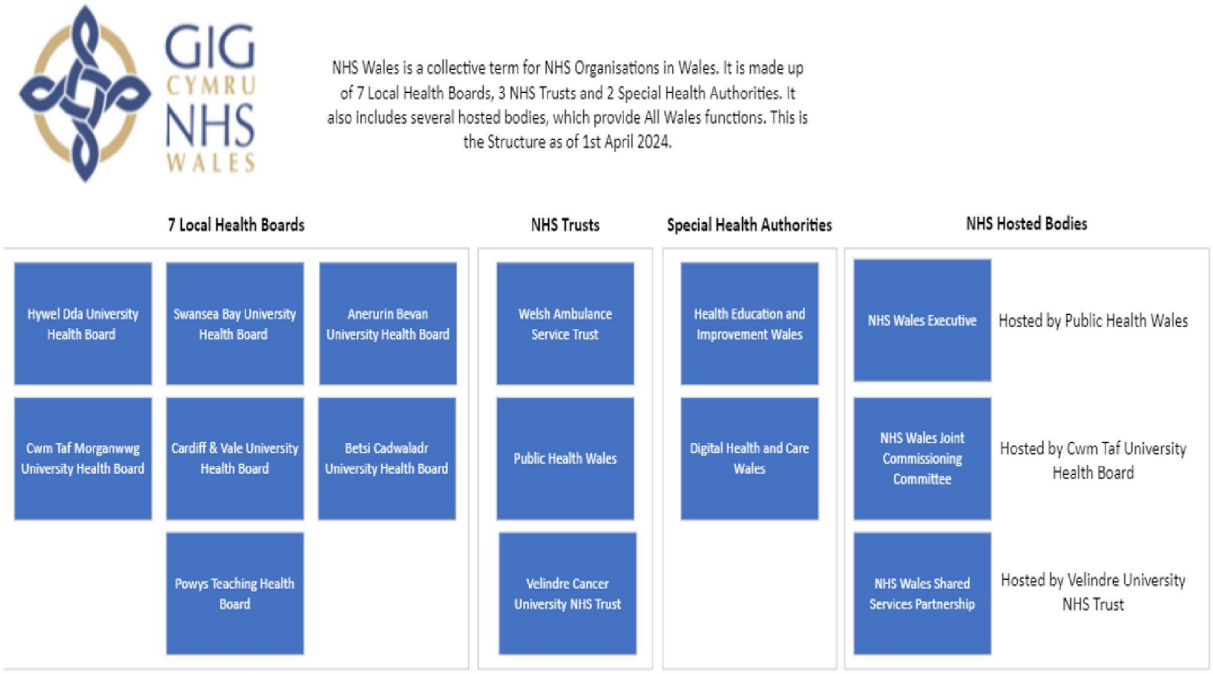


Figure 3: Diagram showing the structure of NHS organisations in Wales as of 1 April 2024



41. Those bodies which are of relevance to the scope of Module 5 are set out below with a description of their role and functions, the most significant of which being the NHS Wales Shared Services Partnership which took to lead on the procurement and distribution of PPE and health supplies during the relevant period, and the NHS Finance Delivery Unit which provided support to the Welsh Government and the NHS in Wales in key response areas such as financial management and governance.

NHS Wales Shared Services Partnership

42. Velindre NHS Trust has the function of managing and providing shared services to the health service in Wales. The NHS Wales Shared Services Partnership is the operational name for the Shared Services Committee of Velindre NHS Trust. The NHS Wales Shared Services Partnership is a hosted organisation and is responsible for exercising Velindre National Health Service Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to local health boards and NHS trusts.

43. The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which is responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended)

prescribe the membership of the NHS Shared Services Committee in order to ensure that all local health boards, trusts and special health authorities in Wales have a member on the NHS Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

44. The NHS bodies (the Partners) in Wales participate in the NHS Shared Services Committee and take collective responsibility for the delivery of the services through a Memorandum of Co-operation Agreement and a Hosting Agreement between the Partners. The Director of Shared Services is designated by the NHS Wales Chief Executive as the Accountable Officer for Shared Services. During the relevant period, the Managing Director accountable to the Chief Executive NHS Wales and Welsh Ministers was Neil Frow.

45. There is no statutory definition of "shared services" beyond meaning the provision of professional, administrative and technical services provided to the health service in Wales. The services provided by the NHS Wales Shared Services Partnership include audit and assurance, counter-fraud, employment, health courier, legal and risk, medical examiner and procurement. Full details about the delivery of specific services will be held with the organisation itself.

46. Before the pandemic, responsibility for the procurement of key health equipment and supplies was the responsibility of the NHS Wales Shared Services Partnership. Its role did not change during the pandemic, but its remit was expanded by the Minister for Health and Social Services on 19 March 2020 to procure and supply PPE to social care settings in Wales. On 25 March 2020, it was expanded to include supplying PPE to the wider NHS, including independent contractors in primary care (GPs, dentists, pharmacies and optometrists).

47. During the pandemic, the NHS Wales Shared Services Partnership worked closely with local government to identify the demand for PPE in social care and it played a role distributing PPE to social care providers.

48. The NHS Wales Shared Services Partnership's Surgical Materials Testing Laboratory played a role in ensuring the PPE provided met technical and quality standards through the provision of medical device testing and technical services regarding medical devices to the Welsh NHS.

NHS Finance Delivery Unit

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

50. I understand that Alan Brace, Director of Finance for the Health and Social Services Group during the relevant period, has provided a statement (reference **M5-WGHSSG-01**) which sets out further information on the work of the Finance Delivery Unit for which Alan was accountable as Director of Finance.

51. Since 1 April 2023, the NHS Finance Delivery Unit forms part of NHS Executive which is hosted by Public Health Wales as referred to above in paragraph 27.

Leadership of the NHS in Wales

52. As noted above I held the role of Chief Executive NHS Wales between June 2014 and November 2021. The Chief Executive NHS Wales role involves the leadership and oversight of appropriate planning, delivery and assurance across the NHS in Wales, working with all NHS organisations. The Chief Executive NHS Wales provides leadership and support to the seven Chief Executives of the local health boards, the three NHS trust Chief Executives, two special health authorities Chief Executives and the Managing Director of NHS Wales Shared Services Partnership.

53. I have commented previously on my experience in Wales of working in an intimate and connected system and this experience was reflected in the way in which I balanced the Director General Health and Social Services and the Chief Executive NHS Wales roles during the pandemic. Although each NHS organisation had their own statutory responsibilities for healthcare services, my dual role allowed me to simultaneously discharge a leadership and representative role for the NHS. It enabled me to set the collaborative and collegiate expectations, requiring organisations to work across boundaries on behalf of the Welsh population's health, not just their own local communities. It also meant that an active, effective, and visible pattern of collective working

was already embedded in the Welsh healthcare system, which supported our pandemic response.

54. In terms of my authority as Chief Executive NHS Wales to issue guidance, set goals or targets for the NHS in Wales, this is closely aligned with my Director General role. Authority to oversee the NHS in Wales is delegated from the Welsh Ministers, through the Director General Health and Social Services and to the chief executives of each NHS body, through the Accounting Officer and additional accounting officer delegations. In this way, the Director General discharges the authority of the Welsh Ministers on the NHS in Wales.

55. With regard to guidance that I issued during the relevant period, and which falls within the scope of Module 5, any such guidance was very much aligned to my role as Director General and Accounting Officer for the NHS in Wales. In practice this primarily related to the issuing of guidance, expectation and direction in respect of managing Welsh public money. I exhibit a letter at **M5/AG/003-INQ000182437** and guidance at **M5/AG/004-INQ000336746**, which I sent to Chief Executives of the NHS bodies in Wales on 30 March 2020. The guidance I issued on 30 March 2020 was developed to support organisations during the pandemic and included guidance on financial management and reporting. The guidance also reminded them that the Welsh Government still expected good governance around spending decisions and that any such decisions should be taken in accordance with relevant guidance such as 'Managing Welsh Public Money' and their Standing Financial Instructions.

56. Other than guidance on managing public money, I was not generally involved in issuing formal guidance specific to matters within the scope of Module 5 as that did not fall within my role as Director General for Health and Social Services. The majority of the guidance that I issued during the Covid-19 pandemic was mostly on matters outside of the scope of Module 5, and which is set out in evidence for other modules to the Inquiry (for example, my evidence in Module 3). That said:

    a) There were some occasions during which I would provide input to the development of guidance relating to PPE. By way of example, I exhibit an email that I sent on 28 March 2020 at **M5/AG/005 - INQ000534359** in which I suggested making it clear within the "Coronavirus Q&A PPE" that we will continue to identify and replenish supplies through existing and new NHS Wales supply contracts and that we were working with UK Government supply arrangements. However, I did not issue that guidance.

b) I cannot rule out ever giving direction and advice in relation to PPE where my authority as Director General for Health and Social Services/Chief Executive of the NHS in Wales helped or to clarify expectations, such as during meetings with the chief executives of the NHS bodies, internal meetings, press conferences and in partnership with the unions.

c) There were also occasions in which I acted as a contact point for external bodies to whom I would send information regarding PPE such as my email to the Royal College of General Practitioners regarding a statement to be made by the Minister on the provision of PPE equipment to primary care which I exhibit at **M5/AG/006 - INQ000513723.** I subsequently wrote to all General Practitioners, local health boards and the Welsh Ambulance NHS Trust on 11 March 2020 which I exhibit at **M5/AG/007 – INQ000395690**. Whilst that letter was primarily focused on updating the recipients on the Covid-19 response, the letter did acknowledge that primary care practices had indicated difficulty in obtaining sufficient PPE and that, as a consequence, PPE was being distributed to all practices and out of hours services.

57. Accordingly, although I was not responsible for issuing formal guidance specific to matters within the scope of Module 5, I would involve myself on matters pertaining to PPE when asked or raised to enable me to retain a broad understanding of the general position regarding the supply and distribution of key healthcare equipment and supplies. This also enabled me to be as helpful as I possibly could in making strategic decisions regarding the NHS in Wales and participating in meetings. I did, however, rely on the NHS Wales Shared Services Partnership, together with the leadership of others within the Welsh Government particularly that of Alan Brace and those part of the Covid-19 Planning and Response structure, to remain closer than I was to the day-to-day operational aspects of the supply and distribution of key healthcare equipment and supplies and to provide me with information as I required. I cannot emphasise enough how helpful these support structures were to me during the pandemic in maintaining an effective balance between retaining strategic leadership in relation to the entirety of the NHS in Wales and having sufficient information and knowledge to become more involved in matters requiring my assistance as Chief Executive of the NHS in Wales, for example should issues need escalation or if my authority was needed such as in signing high value contracts.

58. The witness statement of Andrew Slade (reference M5/WGCPD/01) sets out the role of the Commercial and Procurement Directorate of the Welsh Government, and the witness statement of Alan Brace (reference M5/WGHSSG/01) sets out the role of the Health and Social Services Group of the Welsh Government, and any advice and guidance issued by

those departments in relation to the matters within the scope of Module 5. Any guidance relating to the use and types of PPE was set out in the UK infection prevention control guidance which was developed on a four nations UK basis, and any input required on a Wales basis would be led by senior clinical officials such as the Chief Medical Officer for Wales, Deputy Chief Medical Officer for Wales and the Chief Nursing Officer for Wales. Further information on the UK infection prevention control guidance is set out later in this statement.

59. The NHS in Wales operates under the Welsh Government's NHS Wales Planning Framework which gives statutory guidance on developing three-year plans linked to an NHS body's allocated budget, known as Integrated Medium Term Plans (also referred to as IMTPs) setting out how the NHS body will deliver services to meet the needs of their local population.

60. Following submission of an Integrated Medium Term Plan, based on recommendations from Welsh Government officials, Ministers will decide whether or not to approve the plan. If approved the Chief Executive NHS Wales will issue an accountability letter setting out any conditions for the year ahead. If the plan is not approved the NHS body will need to provide a detailed Annual Operating Plan to provide assurance and ensure smooth and sustainable provision of services to its population over the year ahead and appropriate monitoring and escalation arrangements will be put in place to oversee delivery.

61. The Welsh Ministers report to the Senedd before the end of any three-year accounting period on the local health boards' or trusts' performance. Special health authorities and the other various committees and organisations which form part of the NHS in Wales are not under the same statutory planning duty, however Integrated Medium Term Plans are also submitted by these NHS organisations on a voluntary basis providing plans in the spirit of the planning framework.

62. During the relevant period, the usual planning process of three-year Integrated Medium Term Plans was not realistic given the need for the NHS in Wales to respond quickly to what seemed like a constantly evolving picture. To ensure the planning principles and mechanisms for oversight were not lost, the Welsh Government initially asked health boards for weekly plans in the early phase of the pandemic. Once the position started to stabilise this changed to quarterly operational planning cycles which were introduced in May 2020.

63. Operational Planning Frameworks were issued for each quarter to set out the requirements for the NHS in Wales. During the relevant period the following frameworks

were issued to the NHS in Wales based on which each organisation would need to plan the services that would be delivered in their local areas:

a) NHS Wales Operating Framework - quarter 1, exhibit **M5/AG/008-INQ000182468** refers.

b) NHS Wales Operating Framework - quarter 2, exhibit **M5/AG/009- INQ000336745** refers.

c) NHS Wales Operating Framework – quarter 3 and 4, exhibit **M5/AG/010-INQ000182474** refers.

d) Welsh Government Winter Protection Plan 2020-21, exhibit **M5/AG/011-INQ000300011** refers.

64. The Operating Frameworks, as with the NHS Planning Framework in place prior to the pandemic, did not dictate what services must or must not be delivered, but instead provided to NHS organisations a baseline and the tools to assess the needs of the local population and a requirement to plan for delivery.

65. Included in the Operating Frameworks was information on PPE highlighting to the NHS in Wales that national and local efforts needed to ensure that NHS bodies in quarter 1 considered the re-introduction of routine activities based on the availability of PPE and other key supplies, including ensuring medicines and blood products could be maintained; in quarters 1 and 2 continue to ensure effective training, equipment and supplies for the NHS workforce – including PPE and key transferable skills which were to be updated as necessary in line with emergency guidance; and in quarters 3 and 4 ensure plans demonstrated how services were to be progressively maintained, underpinned with robust clinical prioritisation and patient safety netting arrangements. The plans were also required to reflect how the availability of medicines, PPE, blood, consumables, equipment and other supplies needed, would be maintained. The Operating Frameworks therefore required close working with NHS Wales Shared Services Partnership to assess and identify the needs of each NHS organisation and help them to plan accordingly.

66. As noted above, NHS Wales Shared Services Partnership delivered shared services for each of the NHS bodies in Wales and each of the NHS bodies has a member on the Shared Services Committee, to ensure that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

67. In December 2020 the Planning Framework 2021-22 was issued requiring organisations to develop an annual plan for 2021-22. The 2021-22 Framework built on the quarterly frameworks issued in 2020-21 and drew on the priorities set out in the Welsh Government's Winter Protection Plan. The standard Integrated Medium Term Plan framework was brought back for the 2022-2025 period and the statutory process recommenced.

Chief Executive NHS Wales engagement with the NHS in Wales

68. My role as Chief Executive NHS Wales and as Director General Health and Social Services provided me the opportunity to advocate for the NHS in Wales in a unique way given my access to the Permanent Secretary and Ministers and also with the UK Government. For example, the Permanent Secretary at the time, Shan Morgan, would ask me about any points or issues to raise when meeting with her UK counterpart. PPE supplies was an issue I raised with Shan Morgan, as outlined in the email exhibited as **M5/AG/012- INQ000513729,** noting that being part of the UK supply chain we needed to ensure that population share was calculated equitably. Early in the pandemic, I had concerns that the population share of supplies was not being calculated equitably due to suppliers (including those based in Wales) informing us that they had been told to do business with NHS England only and PPE manufacturers cancelling contracts in Wales in order to supply NHS England on a preferential basis. As a result, I was losing confidence that there was any kind of UK approach as it appeared to me that the UK Government was taking an "England first and only" approach and prioritising PPE supplies and other equipment to England, which would inevitably lead to a lack of equity amongst the Devolved Governments. These concerns were exacerbated by a lack of communication from the UK Government. My concerns were ultimately resolved via the work that was undertaken by Alan Brace and others in the Health and Social Services Group who worked cooperatively with the UK Government to agree procurement for the four nations, and the work of the NHS Wales Shared Services Partnership in coordinating the procurement and distribution of PPE in Wales. Further information about PPE supplied by the UK Government is set out later in this statement.

69. Similarly, I was able to escalate matters to ministers to raise with the Secretary of State for Health in England and with other Devolved Governments in a very direct and timely manner due to my closeness to the Welsh Government, as exhibited in **M5/AG/013-INQ000479929.** This information was immediately fed into the NHS Wales Shared Services Partnership to support its responsibilities for procurement and distribution of PPE

and other health equipment in Wales, as noted in my email to its Managing Director, Neil Frow, exhibited as **M5/AG/014-INQ000513733.**

70. Another aspect of my dual role was bringing together people quickly to address concerns. For example, concerns raised with Members of the Senedd and raised via Ministers would be raised with myself as Chief Executive NHS Wales to seek answers and assurance. As exhibited in **M5/AG/015-INQ000513734**, a constituent of Mick Antoniw, Member of the Senedd contacted him with concerns about desperately needing more gowns and FFP3 masks, which they had tried unsuccessfully to buy from local DIY stores. I was able to send those concerns straight to the local health board and NHS Wales Shared Services Partnership and ask, in addition to addressing the concerns, to be provided with information on the oversight of primary care supplies and how General Practitioners could access health board support rather than feel the need to contact Members of the Senedd. I was also able to ask the Welsh Government to look at a way to have the health desk/ Emergency Contact Centre Wales to look for supplies more broadly as a contingency for tracking problems.

71. There were a few different ways in which I, as Chief Executive NHS Wales, brought together local health boards, NHS trusts and special health authorities in Wales to ensure they worked together and communicated during the pandemic. I think this was achieved effectively through my role despite there being no over-arching body which had control of the activities of the NHS in Wales. I have outlined the main contact points with NHS leaders below. These were more formal contact points and in practice all the chief executives in the NHS in Wales were known to me and were able to contact me directly to discuss any matters of concern. In relation to the supply, distribution and procurement of key healthcare equipment and supplies during the pandemic, as set out elsewhere in this statement, this was coordinated through the NHS Wales Shared Services Partnership which represented an overarching and expert function and acted as a central body for those matters. As I have detailed later in this statement, any difficulties or issues of which I was made aware in respect of the supply, distribution or procurement of key healthcare equipment were referred to them. Accordingly, the Welsh Government did of course retain an interest and oversight more centrally as regards the supply, distribution and procurement of key healthcare equipment, including via updates directly from NHS Wales Shared Services Partnership to the Welsh Government and through the Covid-19 Planning and Response structure. It is however important to emphasise that the work of NHS Wales Shared Services Partnership was crucial during the pandemic particularly in terms of its contact and connection with the healthcare system in Wales and, on a national level, to the Welsh Government. The fundamental and overarching role of NHS Wales Shared Services was

recognised widely by the healthcare system in Wales and also by the Audit Wales report which is exhibited later in this statement.

NHS Wales Chief Executives

72. Formal national contact with the NHS in Wales is through the NHS Wales Executive Board, and local contact and accountability is managed through my performance-led meetings with individual organisations throughout the year. In addition, national calls with NHS chief executives or their deputies, usually weekly, have been a feature of the Welsh Government's operational oversight of the NHS for many years and they continued during the pandemic.

73. As well as establishing the Covid-19 Planning and Response Group (see below in paragraphs 87 to 96 of this statement), to bring NHS leaders closer to decision making in the Welsh Government I established more frequent calls with NHS leaders to discuss pandemic preparation. These calls were regular, often daily, and more frequently when required, throughout the first phase of the pandemic response, and then consistently throughout the remainder of my tenure as Chief Executive NHS Wales.

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

NHS Wales Chairs

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

76. Prior to the pandemic, I would meet with NHS chairs informally a handful of times a year, and I was always available to support them in their roles. During the pandemic, when I needed to consult the NHS chairs directly, I tended to invite them to join my routine calls with NHS chief executives, given that the environment was changing so quickly.

77. The NHS chairs would also meet with the Minister for Health and Social Services quarterly. These meetings were retained during the pandemic, and both prior to and during the pandemic I would arrange these on behalf of, and attend in support of, the Minister for Health and Social Services.

NHS Wales Executive Board / NHS Wales Leadership Board

78. The NHS Wales Executive Board (which, from July 2021, was reset as the NHS Wales Leadership Board) provides the leadership forum to support the oversight and delivery of NHS functions in Wales.

79. The NHS Wales Executive Board provides executive leadership, direction, and oversight of the performance, delivery, quality, and safety of NHS services, workforce, and functions in Wales. It also provides a mechanism through which the Welsh Government can hold NHS chief executives collectively to account for the performance, operation, governance and functions of NHS bodies in Wales. It is important to note that direct accountability is through chief executives to me, through the accounting officer mechanism explained above at paragraph 11, but the NHS Wales Executive Board nevertheless provided an important leadership forum and was critical in maintaining a collaborative approach for Wales throughout the pandemic.

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

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

82. I have explained elsewhere in this statement that a particular and possibly defining feature of the Welsh healthcare sector is its intimacy and the close proximity between individual NHS bodies and, variously, national legislators and policy makers in the Welsh Government, other health bodies and organisations. This proximity to government enabled

rapid communication and discussion at critical points and ensured a constant two-way dialogue between the Welsh Government and NHS bodies in Wales.

Welsh Partnership Forum

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

    a) The recognised healthcare trade unions and professional organisations for the NHS in Wales.

    b) Representatives of senior management for the NHS in Wales.

    c) Representatives from the Welsh Government.

84. Meetings were co-chaired by me, in my capacity as Chief Executive NHS Wales, a Union-nominated chair and an NHS chief executive.

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

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

Covid 19 Planning and Response Group

87. In February 2020, I established the Covid-19 Planning and Response Group for the purpose of bringing together officials from the Health and Social Services Group, NHS bodies in Wales, and the social care sector who were working at a more operational level in response to the emerging pandemic. This helped to support a health-led response to

the initial phase of the pandemic. The Covid-19 Planning and Response Group also provided a basis for ongoing collaboration, and co-design with the wider health and social care systems, and access to health and care expertise outside the Welsh Government. I have exhibited as **M5/AG/016-INQ000083236** (dated May 2022) and **M5/AG/017-INQ000083237** (dated 20 April 2020) the structure of the Covid-19 Planning and Response Group and its links to the wider organisation and externally.

88. The Planning and Response Group reflected my leadership of, and oversight over, the health and social care systems and the Welsh Government's health and social services response to the pandemic. It reported to me, providing me with assurance on reasonable worst case scenario planning, preparedness, emerging risks and issues, and the coordination of our preparation and response across the Health and Social Services Group.

89. The work of the Covid-19 Planning and Response Group would be reported to me and the Chief Medical Officer via its chair Samia Edmonds. I was not however appraised of all discussions that took place in the Group or its sub-groups.

90. Both as Director General Health and Social Services and as Chief Executive NHS Wales I was being updated on the procurement of PPE, lateral flow tests and PCR tests. I was aware of the concern about ventilator shortages against the forecasts of 1,500 ventilator requirements. I was assured that the Health and Social Services Group, NHS Wales Shared Services and the Covid-19 Planning and Response Group were working through these issues, and all knew they had me available to come to if required. Therefore, I would have known at the time general issues and progress and in fact spoke on some of these at press conferences and in conversations with the ministers - but generally felt colleagues were picking them up and responding. Therefore, issues, concerns or recommendations for action to be taken would only if necessary be escalated to me to action, but there was an expectation that the Group worked proactively to share information and identify and resolve issues as they arose.

91. The leadership of the Covid-19 Planning and Response Group and its sub-groups was deliberately balanced between Welsh Government officials and leaders from different parts of the health and care systems. This ensured a high level of collaboration and information exchange from the government to the NHS in Wales, and vice versa. This approach was highly effective and was maintained throughout the pandemic. It also helped to inform our structures and plans as we emerged from the pandemic. Issues of availability

and distribution would have been raised and managed through the Covid-19 Planning and Response Group.

92. The Covid-19 Planning and Response Group did not have a specific role in relation to the procurement of PPE, lateral flow tests and PCR tests and ventilators in Wales during the pandemic and I do not recall having any concerns formally escalated to me directly from the work of the Covid-19 Planning and Response Group or its sub-groups regarding the procurement of PPE or ventilators.

93. I was aware that there were tensions and worries about PPE, but I do not recall having any concerns about communication between NHS bodies in relation to procurement of PPE or other health supplies being raised with myself as Chief Executive NHS Wales during the pandemic. Such tension and worries included general concerns about the availability and levels of supply of PPE in view of the predictions arising from the initial modelling calculations and reliance on the UK Government in obtaining our supplies. There was also a degree of concern to ensure that there were robust processes in place to procure more PPE as required. Such concerns were mostly confined to the early months of the pandemic and, rather than the Covid-19 Planning and Response Group, it would generally be at the meetings with the chief executives with the NHS bodies (including the Managing Director of the NHS Wales Shared Services Partnership) that PPE updates would be picked up. These meetings were an effective forum within which concerns from the NHS bodies regarding PPE and other supplies could be openly discussed. Meetings of the Welsh Partnership Forum were another useful forum within which concerns regarding the availability of PPE (and other concerns relating to PPE such as use) could be discussed with NHS employers and trade unions. I recall unions both in partnership forum meetings and individually having some concerns regarding the need for information around the level of national and local supplies, as well as concerns regarding the issue of PPE to General Practitioners noted in correspondence which was sent to me from the British Medical Association in March 2020 and is set out in detail at paragraph 145 below.

94. The Welsh Government were reactive to such concerns and drew heavily upon the assistance of the PPE Sourcing and Distribution Group and, later, the PPE Procurement and Supply Group in coordinating and responding to concerns about the national supply of PPE.

95. My concerns regarding the availability of PPE were very much eased as time went on and it became clear through regular communication and updates with officials in the Welsh

Government, and from the work of the Health and Social Services Group and the NHS Wales Shared Services Partnership that we had sufficient supplies nationally. Furthermore, once local health boards started to publish their own available supplies of PPE locally alongside our own national supplies, that also helped with local confidence. I was highly cognisant of concerns regarding supply and, in my capacity as Accounting Officer for the NHS in Wales, whenever I was required to approve procurement cases that exceeded the normal financial threshold, I would always ensure that this was done quickly and with urgency when needed. Beyond the Welsh Government's role of ensuring the national supply of PPE, it was however for local health boards to ensure supplies ended up in the right place across their facilities, which in hindsight was not always the case.

96. As noted above; procurement was led by the NHS Wales Shared Services Partnership which was a key part of the NHS in Wales, and its committee comprised of members from each local health board and NHS trust in Wales. The procurement of PCR and lateral flow tests was carried out by the UK Government on a four nations basis. I am not aware of any local health boards, NHS trusts or special health authorities being involved in carrying out procurement of PPE, ventilators, lateral flow tests and PCR tests, or other healthcare equipment and supplies during the pandemic, outside the work of the NHS Wales Shared Services Partnership.

Infection Prevention Control guidance and PPE procurement

97. The Nosocomial Transmission Group, which was chaired by Jean White, Chief Nursing Officer for Wales and Dr Chris Jones, Deputy Chief Medical Officer for Wales, provided a forum to discuss infection prevention control and PPE measures outside the Covid-19 Planning and Response structure. The Nosocomial Transmission Group was concerned with professional questions about what PPE should be used and by whom, including clinical criteria.

98. I am unable to comment on whether infection prevention and control guidance was influenced or driven by stock levels of PPE (in particular, of FFP2 or FFP3 respirators) and do not recall this issue arising from the work of Covid-19 Planning and Response Group. In Wales we followed the UK infection prevention control guidance rather than a specific Welsh version, so this meant that we had to apply and use this in the context of the NHS services and estate in Wales and in accordance with our supplies. I was aware of concerns raised in December 2020 following the identification of the Alpha variant of Covid-19 calling for access to FFP3 masks for all staff working with confirmed or suspected Covid-19 patients, and to commission a review of national PPE guidance. I am aware that the review

by the UK Infection Prevention Control Cell did not identify a change in the mode of transmission between this variant strain and previous circulating strains of SARS- CoV-2 and therefore it was agreed that there should be no changes to the PPE recommendations as was set out in the UK infection protection control guidance until more evidence or data was available. This was set out in advice the Minister for Health and Social Services to which I was a copy recipient as exhibited in **M5/AG/018-INQ000513756.** Outside of this I do not recall any specific communications with the Chief Medical Officer or Chief Nursing Officer on the UK infection prevention and control guidance and PPE. I did not attend the UK Infection Prevention Control Cell, nor the Nosocomial Transmission Group, so it would be for others to comment on whether these were at all judgements made in these UK wide groups.

99. I considered the role of the NHS Wales Shared Services Partnership and the Health and Social Services Group throughout the relevant period as needing to ensure there was a national supply that would allow the UK infection prevention control guidance to be applied. While we were at times very close to having to some items to running out of national supply, the national supply was not overwhelmed. As set out earlier in this statement, the ability to keep up with volume was a concern in the early weeks but this was fixed by our more certain supply lines achieved after wave one. We were also providing PPE well beyond our original assessments to all contractors, NHS wide and social care (and also to funeral homes) so well beyond the original capacity assessments.

The Chief Executive NHS Wales liaison with NHS in Wales in respect of the procurement and distribution of key healthcare equipment and supplies

100. As Chief Executive NHS Wales I did not have a specific role or day to day responsibility for any of the aspects of the procurement and distribution by the NHS in Wales of key healthcare equipment and supplies. I was also not personally involved in the procurement of PPE (whether from abroad or within Wales) during the pandemic.

101. As I have noted above, the Chief Executive NHS Wales is designated by the Welsh Government's Permanent Secretary as the "Accounting Officer for NHS Wales", so while not involved day to day on procurement and distribution I had a responsibility for the financial stewardship of the NHS in Wales. I therefore had responsibility for overseeing the overall value of the contracts awarded by NHS Wales Shared Services Partnership and applying appropriate spending controls to NHS Wales Shared Services Partnership.

102. I did not however routinely become involved in individual contracts entered into by the NHS Wales Shared Services Partnership on behalf of the NHS in Wales. My role therefore excluded:

a) Eliminating the risk and presence of fraud.

b) Limiting the risks of conflicts of interest.

c) Ensuring compliance with public law procurement principles and regulations.

d) Ensuring that there was an effective regulatory regime.

e) Effectively distributing key healthcare equipment and supplies.

f) Building the resilience of supply chains globally and in domestic manufacturing.

103. As I have outlined above in this statement, both as Director General Health and Social Services and as Chief Executive NHS Wales I had general awareness and oversaw those undertaking actions both in NHS Wales Shared Services, and in the Health and Social Services Group. Additionally, I would often speak on matters related to PPE in press conferences and when needed in discussions, for example, with ministers.

104. I have set out below limited instances when I was asked to provide specific input as the Accounting Officer for NHS Wales.

105. On 19 May 2020 the Deputy Director of Finance within the Health and Social Services Group contacted me and sought my approval for the NHS Wales Shared Services Partnership to enter into two contracts for PPE. At that time there was not sufficient funding in the NHS Wales Shared Services Partnership budget to cover the cost of these contracts, so although reviewed by the NHS Finance Governance Committee I needed to provide sign off as the Accounting Officer for the NHS in Wales. The Health and Social Services Group Deputy Director of Finance informed me that the Minister for Finance would be pushing for consequential payments from Her Majesty's Treasury that week.

106. The first order was for 2.5 million FFP3 masks at a cost of £12.150 million and the second order was for 42,620,400 aprons at a cost of £3.917 million. As noted in exhibit **M5/AG/019- INQ000513749** I approved both contracts as there was a need to maintain the PPE pipeline at that time.

107. A further example of when I provided clearance for a contract was in October 2020 when again I was contacted by the Deputy Director of Finance in the Health and Social

Services Group as a previously agreed contract and funding for the purchase FFP3 masks would require unforeseen additional costs as a result of taxes and tariffs introduced by the Turkish government which increased the unit cost by 96p per mask. Consequently, the total amount payable increased by £1.745 million. The Welsh Government had previously approved a payment of £9.486 million. As noted in exhibit **M5/AG/020- INQ000513753** I approved the additional costs associated with this contract.

108. I was also asked to make a decision as NHS Accounting Officer in relation to the provision of assistance to Uganda and Namibia. In October 2021 the NHS Wales Shared Services received a request from the Welsh Government Test, Trace, Protect Team to donate 300,000 lateral flow antibody tests to Namibia. These tests were due to expire in March 2022 and would not be consumed within Wales. Approval to writing-off the stock which was owned by the NHS in Wales and make the items available for potential donation was requested by NHS Wales Shared Services Partnership. This was agreed by the First Minister, subject to approval from Velindre NHS Trust (as the hosting body for NHS Wales Shared Services Partnership) and from myself in my capacity as NHS Accounting Officer. Additionally, the NHS Wales Shared Services Partnership had identified 40 mechanical ventilators donated from various Welsh health organisations at the onset of the pandemic for which there was no demand for in Wales. Colleagues managing the Wales Pandemic Stock confirmed that the NHS in Wales did not need these for resilience purposes. These had therefore also been proposed for donation to Namibia to support its pandemic response. Whilst these ventilators were held at zero value by the NHS Wales Shared Services Partnership, advice from the Welsh Government's Health and Social Service Finance team was that, as this was a novel transaction, approval was required from the NHS Accounting Officer. My agreement was confirmed in my email **M5/AG/021-INQ000513758.**

109. As noted above I would receive general updates on the position with PPE and other health supplies for the NHS in Wales by virtue of my dual role as Director General Health and Social Services and Chief Executive NHS Wales. Information directly from local health boards and trusts on stock levels, distribution, or implementation of infection prevention control guidance, was received via a number of reporting routes into the Health and Social Services Group which, as the Director General Health and Social Services, I also had access to. Many of these are detailed in Alan Brace's statement (reference **M5-WGHSSG-01**) who led on PPE from a Welsh Government perspective and, as set out in paragraph 7 of this statement, played a vital role in relation to the sourcing, storage and distribution of PPE. Additionally, in my dual role, I was aware of the information which NHS bodies were providing to NHS Wales Shared Services Partnership and to the Health and Social

Services Group and I was also aware of the information from NHS Wales Shared Services Partnership to the NHS Finance Delivery Unit and the Health and Social Services Group.

110. I would at times request updates and information from the NHS Wales Shared Services Partnership on stock levels of PPE and key medical equipment and supplies for discussion when speaking more broadly in meetings with professional bodies and unions and with the Minister for Health and Social Services as noted in the email exhibited as **M5/AG/022-INQ000513739.** As the public face for the NHS in Wales I did receive some stock level updates for press conferences, for example as exhibited in **M5/AG/023-INQ000513731** updating the position as of 26 March 2020. I would also be aware of stock levels if escalated to me as a risk either via the Health and Social Services Group or by the NHS chief executives.

111. In my NHS chief executive calls or in my regular meetings with Albert Heaney, who was Director of Social Services and Integration and Deputy Director General, Health and Social Services (from March 2020) I would have information at a strategic level about the distribution of PPE across the NHS in Wales and to the social care sector, which would include escalation of any issues with distribution. For example, in April 2020, as exhibited in **M5/AG/024-INQ000513740** Albert Heaney raised with me concerns received from Cardiff County Council regarding availability of PPE for social care workers.

112. As the Accounting Officer for the NHS, I had information on total spend on PPE and key medical equipment and supplies by the NHS in Wales as I would ultimately sign the accounts for the year. In the two-year period ending April 2022, NHS Wales expenditure on PPE totalled some £385 million of which just over 3% was written off as unusable due to shelf-life expiry. I exhibit the NHS Wales Shared Service Partnership Audit Committee Report at **M5/AG/025-INQ000477059.** Information about how much PPE is currently held on behalf of the NHS in Wales, that is not necessary for pandemic stockpiling and not necessary for day-to-day use in the Welsh health or social care sector, is best obtained from the NHS Wales Shared Services Partnership.

113. The Inquiry has asked at what point in the pandemic did I believe or was I advised that Wales had sufficient stocks of PPE to meet its pandemic needs. As set out earlier in this statement, whilst I was broadly aware of the procurement and distribution of PPE, I was not involved in the day-to-day operational aspects of the supply and distribution of PPE as this was undertaken by NHS Wales Shared Services Partnership and, from a Welsh Government perspective, led by Alan Brace. Accordingly, I am unable to confirm an exact date when I was satisfied that Wales had sufficient stocks of PPE to meet its pandemic

needs but, to the best of my knowledge, it would have been in or around late April/early May 2020. I was aware of this because:

a) the Minister for Health and Social Services gave evidence to the Senedd's Health and Social Care Committee on 30 April 2020 noting that, whilst demand for PPE was likely to remain well above normal, there was enough PPE in the system. A copy of the evidence is exhibited at **M5/AG/026- INQ000087990**.

b) In the First Minister PPE briefing dated 5 May 2020, which I was a copy recipient of, and I exhibit at **M5/AG/027 – INQ000198340**, it was noted that the current PPE situation remained stable.

c) In May 2020, the Welsh Government was in a position to agree mutual aid to other nations, thus indicating that it had sufficient PPE supplies to do so.

d) Meetings of groups such as the Critical Equipment Requirement and Engineering Team, which was established to focus on ensuring sufficient supplies of healthcare equipment such as PPE, began to meet less regularly from June 2020 in view of improvements in the supply and distribution of PPE.

114. As set out in paragraph 126 below, I was also aware of an issue regarding stock availability in relation to FFP3 masks in October 2020, but my understanding is that the overall position on stocks of PPE remained stable.

115. The Inquiry has also asked whether I had any concerns that Wales had procured more PPE than was necessary during the pandemic. As set out above, I was aware in May 2020 that Wales had sufficient PPE supplies such that it was able to agree mutual aid to other nations, and in July 2021 NHS Wales Shared Services Partnership donated excess PPE to Namibia which I approved as the Accounting Officer for the NHS in Wales. I was not concerned, however, that Wales had overspent in relation to the procurement of PPE, or procured too much PPE, as we needed to secure appropriate supplies, give confidence to the healthcare system and staff and secure funding to cover the demand that Covid-19, in its various waves, caused. Our approach meant that those working within the health service in Wales had sufficient levels of stock to enable protection from the disease and also that we were in a position to assist others who were in need. I was also mindful of the fact that, even with demand modelling, it was unlikely to be possible to know exactly how much PPE would be needed, and it was certainly better to slightly overbuy than to risk running out of PPE. As a matter of principle, I do not consider having a contingency of PPE

supplies to be a bad thing. As is also set out above, in my capacity as the Accounting Officer for the NHS in Wales, I agreed to write off 3% of expenditure of PPE as unusable due to shelf-life expiry for the two-year period ending April 2022. In view of the demands for PPE and the pressures arising out of the pandemic, including those associated with the global supply chain, I acknowledge that it was often very difficult to balance the need to secure an appropriate volume of PPE bearing in mind its shelf-life, and I feel that the writing off of 3% expenditure was reasonable in the circumstances particularly given that this meant 97% of the stock was used and not written off.

Accountability of the NHS Wales Shared Services Partnership

116. Responsibility for the procurement of key health equipment and supplies was the responsibility of the NHS Wales Shared Services Partnership both before, during and after the pandemic as set out elsewhere in this statement. My role and the governance arrangement between the Welsh Government and the NHS Wales Shared Services Partnership did not change, although there was increased reporting by the NHS Wales Shared Services both to the NHS in Wales and the Welsh Government of its procurement activities, and I would have more frequent touch points with its executive team just as I was doing with all the NHS bodies in Wales during this period.

117. The Velindre University NHS Trust Audit Committee for the NHS Wales Shared Services Partnership has a role to advise and assure the Shared Services Partnership Committee and the Accountable Officer on whether effective arrangements are in place to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

118. In respect of contracts awarded by the NHS Wales Shared Services Partnership, any conflicts of interests would be monitored, recorded, declared and assessed by Shared Services itself. As Chief Executive NHS Wales I did not routinely have all conflicts of interest reported to me unless it was a matter that required a decision on a matter upon which the Accountable Officer for NHS Wales Shared Services Partnership and Velindre NHS Trust could not take.

119. An important and significant point to note in the accountability of Velindre NHS Trust in relation to its governance of the NHS Wales Shared Services Partnership is that it was not just accountable to me as Chief Executive NHS Wales but to each of the NHS bodies in Wales for which it delivered shared services.

120. The function of managing and providing shared services to the health service in Wales was given to Velindre NHS Trust by the Velindre National Health Service Trust (Establishment) Order 1993/2838. The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (S.I. 2012/1261) require Velindre NHS Trust to establish a Shared Services Committee which is responsible for exercising the Trust's Shared Services functions. The Regulations prescribe the membership of the Shared Services Committee in order to ensure that all NHS bodies in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

121. The governance of Velindre NHS Trust in relation to the performance of the NHS Wales Shared Services Partnership was therefore not only within my remit as Chief Executive NHS Wales but also appropriately within the remit of the individual boards for each local health board and trust which it served.

122. There were a number of ways in which NHS Wales Shared Services Partnership reported into the Welsh Government and were held accountable which went beyond purely my role as Chief Executive NHS Wales. NHS Wales Shared Services Partnership provided briefings around PPE to Ministers, Welsh Government officials, NHS chief executives and the Welsh Local Government Association (for social care) as well as supporting technical briefings with the Unions and providing information to the press. Furthermore, information was provided on a very regular basis to numerous central groups with health board representation that had been set up to respond to Covid-19. In particular, PPE had been discussed frequently on my NHS chief executive calls on a Monday, Wednesday and Friday and Neil Frow, the Managing Director of NHS Wales Shared Services also provided health board and trust chief executives the opportunity to highlight any particular concerns at bi-weekly meetings he held with them. As noted above, the NHS Wales Shared Services Partnership also sent NHS chief executives and officials in the Health and Social Services Group details of the stock and orders position in respect of the key PPE lines on a regular basis and updated Albert Heaney in terms of social care deliveries for discussions with Directors of Social Services.

123. By way of example. on the 13 July 2020, the Managing Director, Neil Frow emailed to highlight a significant milestone within the supply chain, logistics and transport of support for Covid-19 with the NHS Wales Shared Services Partnership triggering over 200,000,000 items of PPE being receipted, picked, packed and distributed by the NHS Wales Shared Services Partnership warehouse and logistics team since the pandemic started. A copy of this email is exhibited as **M5/AG/028- INQ000513750.** Neil Frow noted in that email that it

was important to recognise that none of this had been or would be achievable going forward operationally, without the dedication and commitment of the NHS Wales Shared Services Partnership staff and a central shared service supporting the health service and social care in Wales, something which I whole heartedly echo and wish to highlight with thanks to those who were part of the NHS Wales Shared Services Partnership during the pandemic.

124. As responsibility for the procurement of key health equipment and supplies continued to be the responsibility of the NHS Wales Shared Services Partnership any concerns about procurement, distribution or quality of PPE and healthcare supplies that were received by myself, either in my capacity as Chief Executive NHS Wales or as Director General Health and Social Services would be raised with the NHS Wales Shared Services so I could have assurance that they would be addressed. For example, in March 2020 I heard concerns about the supply of PPE to frontline workers from the British Association of Physicians of Indian Origin (BAPIO) Wales, as noted in their letter exhibited as **M5/AG/029-INQ000513728**. This was raised with Neil Frow at NHS Wales Shared Services by email exhibited as **M5/AG/030- INQ000513727.**

125. Concerns from the NHS Wales Shared Services Partnership would also come to me for escalation through the Welsh Government. For example, on the 27 March 2020 Jonathan Irvine, the Director of Procurement and Health Courier Services at the NHS Wales Shared Services Partnership contacted me to request that I escalate to the Minister for Health and Social Services the issue of PPE manufacturers cancelling contracts in Wales in order to supply NHS England on a preferential basis. A copy of this email is exhibited as **M5/AG/031-INQ000513736.** Further information on this issue is provided below in paragraphs 137 to 139.

126. A further example, in October 2020 NHS Wales Shared Services Partnership were experiencing delays in extracting large volume consignments of 3M FFP3 facemasks into Wales. At the time 1.8 million units were awaiting customs clearance in Turkey and no confirmed delivery date had been provided. An expected order for a further 1m units had cancelled by the seller. The PPE team provided a briefing to the Minister for Health and Social Services dated the 30 October 202 by email, exhibited as **M5/AG/032-INQ000513755.** I was copied in and confirmed to the Minister that this had been picked up in the NHS chief executive call that day as a matter for securing contingency arrangements.

Stocktaking and modelling

127. The NHS Wales Shared Services Partnership was responsible for gauging and modelling demand for PPE in Wales during the pandemic and is best placed to provide detailed information in relation to how modelling was carried out, and the challenges this presented.

128. I am aware that initially, the NHS Wales Shared Services Partnership worked with NHS bodies to obtain information on local stocks and estimate short-term demand. Each health board had its own system for projecting demand and managing stocks. Local authorities came together to try to work out the demand for care homes and domiciliary care, but this proved difficult and early estimates of demand quickly grew as guidance on the use of PPE changed.

129. The Welsh Government secured support from a military logistics team. The team reported on 2 April 2020 and recommended central Shared Services modelling of demand. That report, exhibited as **M5/AG/033-INQ000299126**, and the wider assistance provided by the military in relation to PPE during the pandemic is described in further detail in the statement by Andrew Slade (reference **M5/CPD/01**).

130. With help from the NHS Wales Finance Delivery Unit, the NHS Wales Shared Services Partnership started to develop its working model, drawing on the rate of items being issued, and a reporting mechanism to track and report on orders and stock levels for PPE. NHS Wales Shared Services Partnership also obtained feedback and tested assumptions with NHS bodies. The Welsh Local Government Association and local authorities were also involved in developing the demand model for social care.

131. The NHS Wales Shared Services Partnership hired Deloitte in late April 2020 to review the modelling and suggest further improvements. Deloitte helped to develop a more detailed and formal supply and demand model, adding reporting functionality that Shared Services did not have the capacity to deliver. I was kept updated on the work of Deloitte via my Director General Health and Social Services role as Alan Brace, Director of Finance reported into me through the Finance Delivery Unit work, as noted in exhibit **M5/AG/034-INQ000513745** which included Deloitte's status update report exhibited as **M5/AG/035-INQ000513746.**

132. I understand that the modelling developed by Deloitte was an important tool and overall effective but as noted above the NHS Wales Shared Services Partnership would be better placed to comment on its experience of how useful such a system was.

Fit testing of PPE

133. As far as I am aware the NHS bodies Wales and the NHS Wales Shared Services Partnership did their best to factor in the need for a variety of sizes of PPE to protect staff however, I do recognise that this was and continues to be an important concern.

134. At the start of March 2020, the NHS Wales Shared Services Partnership Managing Director, Neil Frow, provided me with a Covid-19 preparedness update, exhibited as **M5/AG/036-INQ000513721**. In this update it identified as a specific issue 'Fit Testing Kits' which noted that there was not at that time a clear picture on what health boards and trust required around fit testing training and fit testing kits across NHS Wales. I understood NHS Wales Shared Services Partnership had several questions about how health boards had been approaching fit testing to date and worked with health boards and trusts so they could be clear of the requirements moving forward.

135. The Chair of the Welsh Intensive Care Society copied me into correspondence to the Minister for Health and Social Services which set out how staff were understandably anxious about the adequacy of PPE, particularly as demand for PPE increased. A copy of this letter is exhibited as **M5/AG/037-INQ000513748**. The Welsh Intensive Care Society, appreciating the challenges associated with PPE distribution, highlighted that limitations and changes to supply were often poorly communicated to the clinical front-line. In their letter an example was provided noting that FFP3 masks came in different shapes and sizes, but an abrupt change in mask provision did not allow adequate time for large numbers of staff to be fit-tested to ensure safety (or to source alternatives) before existing stocks were exhausted. This was shared with the NHS Wales Shared Services Partnership as well as officials in the Health and Social Services Group.

136. In learning lessons from the Covid-19 pandemic I consider that working to ensure adequate PPE designed for the diverse workforce of the NHS is important, as well as ensuring fit testing training is regularly updated.

PPE supplied by the UK Government

137. While we were, and remain, grateful for the work of colleagues in the UK Government, including the Department of Health and Social Care for their efforts in suppling PPE to the four nations, I was conscious from March 2020 onwards that one of the limitations for use of PPE that concerned me was that we were dependent on the UK supply chain for replenishment and equitable access. If that did not happen, our stock (and this would be true of other Devolved Governments) would be used quicker than our ability to procure.

138. In March 2020 the Minister for Health and Social Services was in discussions with the Secretary of State for Health and on 27 March 2020, I briefed him by email, exhibited as **M5/AG/038-INQ000513742,** which noted the supply issues we were experiencing in Wales. While we had our own suppliers for the NHS in Wales there was a great pressure across the NHS to access the right balance of supplies. The UK at the time had, we understood, made a decision to hold all supplies other than to NHS England. We had been advised this was not meant to be disrupting normal Welsh supplies, but suppliers were not engaging with us under a "direction" from NHS England or the UK Government, whether intended or not intended, which was limiting our PPE supply chain. I felt that perhaps a UK approach might be more effective to ensure the NHS had what it needed, but we would need to be reassured that Wales would get the access it required to supplies when we needed it. There was an emerging discussion about if supplies – whether ventilators, PPE or others – would start to be distributed to an assessment of need rather than equity. The concern was that in planning terms this could create concerns for Wales about resilience and business continuity.

139. The procurement for the four nations was subsequently agreed and Alan Brace and others in the Health and Social Services Group worked with the UK Government to progress this. We were fortunate in Wales that the supply of PPE was overall stable in Wales; however, I do not think that would have been possible had it not been for the efforts of the NHS Wales Shared Services Partnership and colleagues in the Welsh Government in identifying additional sources of PPE.

140. I am aware that the Department of Health and Social Care published data on the provision of PPE by the UK Government to Devolved Governments, including Wales. I exhibit a Ministerial Advice at **M5/AG/039-INQ000235909** informing the Minister for Health and Social Services that the Department of Health and Social Care intended to publish data which showed that the Welsh Government had received 3.3 million items of PPE from the UK Government between 6 April 2020 and 17 June 2020. As set out in the Ministerial Advice, the data table on PPE shared by the UK Government with Wales for that period was as follows:

Table 4: Table listing the PPE from the UK Government to Wales for the period 6 April 2020 – 17 June 2020

	Wales	
	6th April – 17th June	
	Apron	1,000,000
	Body Bags	525
	Clinical Waste bags	0
	Eye Protectors (all)	0
	Face Mask FFP2	0
	Face Mask FFP3	500,040
	Face Mask IIR	1,000,000
	General Purpose De	0
	Gloves*	830,000
	Hand Hygiene	0
	Gowns	10,309
	Type II Mask	0
	Total	3,340,874

141. Since 17 June 2020, my understanding is that UK distribution of PPE to the Devolved Governments significantly diminished to nil or virtually nil. During November 2020, the NHS Wales Shared Services Partnership received approximately 300,000 PPE items (FFP3 masks) from the Department of Health and Social Care due to challenging market conditions, but that transfer was on a full-cost recovery plus distribution cost basis.

142. The majority of the PPE issued to health and social care settings in Wales during the relevant period was sourced directly by the NHS Wales Shared Services Partnership through local, national and international procurement routes. The Welsh Government published weekly management information on PPE items issued to health and social care in Wales by the NHS Wales Shared Services Partnership, but the data included both PPE procured directly by the NHS Wales Shared Services Partnership as well as PPE distributed to the NHS Wales Shared Services Partnership by the UK Government and was not broken down as part of publication. I exhibit the management information update on PPE items issued during the Covid-19 pandemic up to 27 March 2022 at **M5/AG/040-INQ000227378** which confirms that, since 9 March 2020, the NHS Wales Shared Services Partnership issued over 1.3 billion items of PPE to the health and social care sectors in Wales.

143. If the Inquiry requires further information about the exact proportion of PPE that was ultimately used in Wales during the pandemic which came through the Department of Health and Social Care/UK Government and the NHS Wales Shared Services Partnership,

the NHS Wales Shared Services Partnership would be best placed to provide such information.

Liaison with representative bodies and unions

144. I was in contact with the British Medical Association throughout the relevant period, and additionally officials in the Health and Social Services Group also met regularly to update on PPE and testing with the British Medical Association, Royal College of Nursing, Care Forum Wales and many others.

145. In March 2020, I was aware through the British Medical Association of the increasing concern among General Practitioners about whether PPE would be issued. I telephoned David Bailey at the British Medical Association to confirm that the Minister for Health and Social Services had agreed access to pandemic stocks and that the warehouse was pulling packs and distribution together to be issued on 9 March 2020 to all practices. I confirmed this exchange in an email to officials dated 7 March 2020, exhibited as **M5/AG/041-INQ000513722**. I also contacted the Royal College of General Practitioners on the 8 March 2020 to confirm that a formal announcement on PPE supplies for primary care would be made the next day. A copy of this email is exhibited as **M5/AG/006-INQ000513723.** I updated the Minister of Health and Social Services on 8 March 2020 that the Royal College of General Practitioners and the British Medical Association were very supportive of the PPE protection decision and distribution. My email to the minister is exhibited at **M5/AG/042-INQ000513724.**

146. I was also provided with correspondence sent on the 21 March 2020 by the British Medical Association to the Prime Minister, Boris Johnson, setting out its deep concerns regarding the inadequacy of providing necessary PPE to the medical profession to enable safe treatment of patients with Covid-19 infection. A copy of the letter is exhibited as **M5/AG/043-INQ000097910.** As outlined in my email to the deputy Chief Medical Officer and officials in the Health and Social Services Group, exhibited at **M5/AG/044-INQ000513725**, the British Medical Association was clear that while it did not feel a public dispute on this would be helpful in Wales, it insisted on PPE being supplied in line with the World Health Organization guidance and latest research as follows:

a) Health care workers involved in the direct care of patients should use the following PPE: gowns, gloves, medical mask, and eye protection (goggles or face shield).

b) Specifically, for aerosol-generating procedures (e.g. tracheal intubation, non-invasive ventilation, tracheostomy, cardiopulmonary resuscitation, manual

ventilation before intubation, bronchoscopy) health care workers should use respirators, eye protection, gloves and gowns; aprons should also be used if gowns are not fluid resistant.

147. At that time although we had pressures, we had a good system for supplying the NHS and social care via the NHS Wales Shared Services Partnership. The criticism from the British Medical Association was focused on what PPE was being recommended for which we followed the advice of the UK infection prevention control guidance, as outlined above in paragraphs 97 to 99. During the relevant period, if health boards were interpreting the UK infection prevention control guidance in different ways in local areas, I do not recall being explicitly informed of this. Public Health Wales were part of the UK Infection Prevention Control Cell and the Nosocomial Transmission Group and if health boards had queries regarding interpretation, then those structures would have been best placed to assist, together with senior clinical officials within the Welsh Government such as the Chief Nursing Officer for Wales. At the time my focus was ensuring that the Health and Social Services Group and NHS Wales Shared Services Partnership were working to secure adequate national supply of key healthcare equipment and supplies. However, in hindsight, and particularly following the evidence provided during the course of module 3 of the UK Public Inquiry, I recognise that there were distribution challenges which did result in instances of healthcare workers who were unable to obtain PPE or were so concerned about the availability of PPE that they adopted unsafe infection prevention control practices.

148. I am aware that the British Medical Association and Welsh Trades Union Congress issued a joint statement in April 2020 asking for clarity on stock and supply of PPE in Wales, exhibit **M5/AG/038-INQ000513742** above refers. The response to this was led by the Minister for Health and Social Services and First Minister's office with officials leading on PPE from the Health and Social Services Group supporting them. Exhibited as **M5/AG/045-INQ000513741** is an email from the Minister for Health and Social Services special adviser summarising the actions taken across the Welsh Government to address the concerns raised in the joint statement. As noted, I took up the action of speaking to the Royal College of Nursing to ascertain its views and provide assurance of the actions being taken by the Welsh Government to address the concerns noted in the joint statement. The wider work in response focused on supporting communication lines between NHS organisations and unions to avoid matters reaching the stage where they escalated.

149. In April 2020, I was provided with advance notice of a press release which noted that a third of surgeons and trainees surveyed in Wales by the Royal College of Surgeons (RCS)

said they believed they had an adequate supply of PPE in their health board, enabling them to do their jobs safely. However, more than half (57%) said there had been shortages in the past 30 days. A copy of the press release is exhibited as **M5/AG/046-INQ000513744** and a copy of the email to me exhibited as **M5/AG/047-INQ000513743.**

150. As noted earlier in this statement, the availability of PPE was also regularly picked up and reported on in the Welsh Partnership Forum meetings (noted above in paragraphs 83 to 86) to respond to guidance issues, and any concerns. This featured less as the pandemic progressed and availability and supply became more secure, including through assurance taken by unions of transparent reporting nationally and through local health boards.

Lesson learned and reflections

151. In September 2020, an internal review of the Health and Social Services Group response structure to Covid-19 was undertaken and signed by me in my capacity as Director General for Health and Social Services Group and by the Chief Medical Officer. I exhibit a copy of this as **M5/AG/048-INQ000066465**. In relation to PPE, the review found evidence of strong partnership working, highlighting the work of the Health Countermeasures Group in bringing together a team to manage PPE sourcing and distribution. I agree that in Wales we saw a good example of partnership working and that was a real asset for our approach to PPE and health supplies.

152. The review also noted the significant offers of PPE and other equipment from suppliers quickly become difficult to manage. The review further reported significant pressures in the very early stages of the pandemic on the Social Services and Integration Directorate from local authorities and care providers, to source and distribute PPE to the social care sector, and that it was sometimes difficult to engage with partners who were focused on health about the needs of the care sector. This is something I would like to see improved in the event of a future pandemic to ensure clear lines of communication between health and social care.

153. The review also highlighted examples of good partnership working across the Health Departments in the four nations of the UK. A suggestion for improvement included seeking clarity from the Department for Health and Social Care on its structure for response, and to work with health departments in the Devolved Governments to avoid surprise announcements. It is important to note that the scope of the review was far broader than the scope of Module 5; for example, the reference to surprise announcements made by the Department for Health and Social Care was, to the best of my knowledge, a general reference to Wales being regularly unsighted on UK Government plans for campaigns and

announcements on a range of topics such as a policy announcement which was made by the UK Government on testing on which Wales was not sighted, and updates to the UK infection prevention and control guidance. That said, the recommendations set out in the review are equally applicable to matters relating to the procurement of healthcare equipment and supplies, and I would definitely recommend the avoidance of surprise announcements as a good learning point. Although Wales has operational independence from England in accordance with the terms of the devolution settlement, the fact remains that there are advantages from working closely with the UK Government on achieving a shared objective such as keeping our respective nations safe from disease. Where policy decisions, which may impact Wales, are made by the UK Government without input from the Welsh Government and at short notice, it can have the effect of putting Wales on the back foot of developing its own policy decisions by placing it under pressure to react quickly and without all the relevant information. Furthermore, as I have outlined in this statement there was worry and anxiety in the early part of the pandemic that PPE supplies for Wales would be affected by areas of increased transmission in England and leave us vulnerable. While these concerns did not materialise strong communication on a four nations basis would improve relations and efficiency.

154. The Audit Wales report 'Procuring and Supplying PPE for the COVID-19 Pandemic' dated April 2021 and exhibited as **M5/AG/049-INQ000214235**, was a useful external intervention that reflected on our actions and advised on potential improvements that could be made. We saw this as a positive report, setting out the experience we had been through, and the actions taken. This report reflected on how the NHS in Wales spend on PPE use before the pandemic went from approximately £8 million a year to one that was projected at the time of the report to be £286 million for 2020-21. As I have noted above, in the two-year period ending April 2022, NHS Wales expenditure on PPE totalled some £385 million which was an unprecedented change of scale. The availability of an existing national shared services procurement and distribution system was critical to enabling us to scale up procurement and supply for Wales.

155. The second review of the Health and Social Services Group's response structure was completed in October 2021 and is exhibited as **M5/AG/050-INQ000022616.** This made no specific findings or recommendations in relation to PPE, but it reported that the procurement of goods and equipment was highly praised, particularly in relation to the supply of PPE.

156. In my last letter to the then Permanent Secretary of the Welsh Government, Shan Morgan, dated 29 October 2021 and exhibited as **M5/AG/051-INQ000083234**, which was shortly

before I stepped away from my role as Chief Executive NHS Wales and Director General Health and Social Services, I reflected that "*reliable sourcing of PPE remains critical to ensuring ongoing delivery of appropriate PPE to primary, community, acute, social care and independent hospital settings. It is imperative that we continue to horizon scan as the scientific evidence continues to develop and informs infection prevention control guidance which drive PPE policy*". I remain of this view and consider that we need to remain vigilant and ensure that PPE policy and modelling for procurement and preparedness keeps pace with the scientific advice.

Statement of Truth

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

Signed: **Personal Data**

Dated: 17 January 2025