Witness Name: Stephanie Howarth
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UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF STEPHANIE HOWARTH

I, Stephanie Howarth, will say as follows; -

Preface

1. I am providing this statement in response to a request under Rule 9 of the Inquiry Rules 2006 referenced **M6/SH/01** on behalf of the Welsh Government's Knowledge and Analytical Services. This statement relates to the period 1 March 2020 to 28 June 2022.

2. The Covid-19 pandemic was unprecedented for all of us, with impacts on lives, livelihoods, and our very way of living. On behalf of my team and myself, I would like to extend our deepest sympathies to all those who were affected, and particularly to those who lost loved ones or have suffered lasting health impacts.

3. I would like to put on record my thanks to colleagues and all our partners for their commitment and dedication during this extraordinary period.

Background

4. I am the Chief Statistician and Head of Profession for statistics in the Welsh Government. I was appointed as interim Chief Statistician from 20 July 2020, and then on a permanent basis from February 2021. Responsibilities of the Chief Statistician include being the principal advisor to the Welsh Government on statistical matters, ensuring compliance with the Code of Practice for Statistics, contributing to the leadership of the Government Statistical Service, and building statistical capability and capacity. I have sole responsibility for the publication of official statistics by the Welsh Government, with a decision-making role independent of Ministers. The

responsibilities of a statistics head of profession are set out on the Analysis Function website, the relevant extract of which I attach as exhibit **SH/01–INQ000271835.** As Chief Statistician, I also lead the operations of the Statistical Services division within the Welsh Government.

5. I have been assisted by Glyn Jones in writing this statement. As the previous Chief Statistician, Glyn Jones led the analytical response to the pandemic from the activity prior to the first national lockdown until the end of July 2020, at which point he was promoted into a Director role, as Chief Digital Officer. Parts of this statement refer in the third person to "the Chief Statistician" to represent the activity which either Glyn Jones led prior to July 2020, or I led from July 2020 onwards. I have also been assisted by a number of colleagues working within my team.

Role of Knowledge and Analytical Services

6. Knowledge and Analytical Services within the Welsh Government comprises a range of analytical professions and services, including statistics, social research, economics, geography, data science and information management. The role of Knowledge and Analytical Services is to provide:
    a. assistance to policy colleagues on data requirements and new data collections, and to publish official statistics;
    b. research to describe, explain and predict changes in social and economic structures, attitudes, values and behaviours;
    c. geographical data, guidance on the use of digital map data, and aerial photography; and
    d. a library of information resources and advisory service on information research.

7. Knowledge and Analytical Services and its Statistical Services team played a significant role during the specified period in collecting, analysing, disseminating, and advising on data and statistics. Social researchers played a role in the provision of qualitative and quantitative evidence, including evaluation. Evaluation activity was more likely to be in relation to pandemic recovery, rather than the pandemic response itself as evaluation is a retrospective examination which takes time to complete. The work done by social researchers therefore focused on the longer-term policy

interventions around recovery, although some limited evaluation work was carried out on response interventions (for example on self-isolation support payments).

8. At the outset of the pandemic, Knowledge and Analytical Services was part of the Welsh Government's Health and Social Services Group, reporting to the Director for Mental Health, Vulnerable Groups and NHS Governance. Although part of the Health and Social Services Group, Knowledge and Analytical Services provided analytical services for all groups in the Welsh Government. From January 2021, Knowledge and Analytical Services moved from the Health and Social Services Group to the Digital, Data and Technology Directorate, reporting to the Chief Digital Officer, who in turn reported to the Permanent Secretary. This organisational change was beneficial as it brought together digital, data and analysis functions alongside each other and also moved the division under the management of a previous Chief Statistician which further strengthened analytical knowledge and leadership. Exhibit **SH/02–INQ000271861** shows an organogram of senior individuals in Knowledge and Analytical Services and its reporting line within the Welsh Government.

Analytical Resourcing

9. There were approximately 125 statisticians, 120 social researchers, 20 economists and 20 geographic analysts working for the Welsh Government during the pandemic period, as well as a small additional number in arm's length bodies. There were also a small number of individuals from other analytical professions, such as data science and operational research (fewer than 10 in total). All analysts are professionally accountable to their head of profession, regardless of where in the organisation they work.

10. The number of analysts in the Welsh Government is considered to be small when compared to the Scottish Government and some UK government departments. There are benefits to being a small analytical function which were valuable during the pandemic, such as an enhanced ability to collaborate and communicate across teams and topic areas, but it also presented challenges in terms of the ability to resource all demands.

11. All people involved in the production of statistics are part of the Government Statistical Service, with professional statisticians (i.e. those recruited in line with the profession's

competency framework) part of what is known as the Government Statistician Group. All members of the Government Statistician Group have professional accountability to the Chief Statistician and Head of Profession for statistics. Approximately two-thirds of statisticians within the Welsh Government are based in the centralised Statistical Services Division, with a further third based in a variety of Welsh Government policy teams outside of the centralised statistics team.

12. Statisticians work collaboratively with policy and operations teams in the delivery of their objectives. The role of statisticians in the Welsh Government is to:

    e. Provide evidence for policy development.
    f. Help monitor policy effectiveness.
    g. Help allocate resources or target funding to support objectives.
    h. Provide advice on capturing new data.

13. Statistical Services in Knowledge and Analytical Services played a significant role in collecting, analysing, disseminating and advising on data and statistics relevant to the Welsh Government's response to the pandemic throughout the specified period. This included the following roles:
    a. Establishing new data collections.
    b. Acquiring data from other organisations (public sector, third sector, private sector).
    c. Analysis and advice for Ministers and officials on Covid-19 data, including compilation of the weekly "data monitor".
    d. Publishing and communicating regular Covid-19 data and statistics.
    e. Contributing to the work of the Technical Advisory Cell and Technical Advisory Group.
    f. Working with public bodies in Wales (e.g., Public Health Wales, Digital Health and Care Wales, and across the UK (particularly the Office for National Statistics, but also UK government departments) on statistical matters.
    g. Leading engagement on contributions to UK-wide dashboards and analysis (for example, working with the UK Government's Civil Contingencies Secretariat).

14. The work of Knowledge and Analytical Services is distinct from and complements the roles of Public Health Wales and the Welsh Government's Technical Advisory Cell and the wider Technical Advisory Group. The Technical Advisory Cell and Technical Advisory Group provided scientific advice and modelling to inform the pandemic

response, often drawing on data collected by Knowledge and Analytical Services, but also utilising data and advice from the UK Government's Scientific and Advisory Group for Emergencies ("SAGE"). Statistical Services had limited involvement in modelling to support the pandemic. Public Health Wales led on the collection, analysis and dissemination of rapid surveillance data for Covid-19, covering topics such as test positivity, case rates, deaths and vaccination uptake.

15. The pandemic saw an unprecedented reprioritisation of analytical resources, with many routine areas of work paused or cancelled. As a result of increasing analytical demand, the Covid-19 analysis hub was stood up in Knowledge and Analytical Services on 23 March 2020. The hub provided a central point of coordination within the Welsh Government for Covid-19 data and statistics. It operated on a 7-day-a-week basis until 17 May 2021, at which point routine weekend and bank holiday cover was stood down. The hub was responsible for:

    a. Acquisition of new data related to Covid-19 (e.g., cases and deaths initially, and then progressing to topics such as care homes, testing, contact tracing and more).
    b. Information sharing with Ministers and policy officials.
    c. Public dissemination of data and statistics.
    d. Analytical support for the 21-day review process.
    e. Quality assurance and support for Ministerial press briefings and media queries.
    f. The co-ordination of ad-hoc analytical requests (from both internal and external sources, including Senedd questions and freedom of information requests).
    g. Provision of data for UK-level dashboards, analysis and publications.

16. Outside of the hub team, analytical leads across all topic areas assisted the hub, as well as providing analysis on Covid-19 as it related to their own topic areas. For example, the economic and labour market statistics team led on analysis related to the impact of the pandemic on the economy and on workforce. In April 2020 a new Data Science Unit was established (a plan which pre-dated the pandemic). This unit provided support on accessing and using new sources of "big data", for example mobility data.

17. I led the Covid-19 analysis hub from its establishment, prior to being appointed Chief Statistician. The size and structure of the hub evolved over the course of the pandemic.

Initially a team of seven (including statisticians and administrative support), it grew to include many more individuals who contributed significant parts of their time alongside existing responsibilities. From autumn 2020, many of the key roles became dedicated full-time roles in their own right, rather than being staffed on a "voluntary" basis alongside other responsibilities. Exhibit **SH/03-INQ000066083** (dated March 2020) and **SH/04-INQ000066084** (dated May 2021) show two iterations of the structures used for Covid-19 analysis and statistics in the Welsh Government. The structure changed and evolved over the course of the specified period in response to the changing analytical demands of the pandemic.

18. This unprecedented redeployment of analytical resources was only possible due to the cancellation or postponement of considerable amounts of regular statistical activities. In the normal course of events Knowledge and Analytical Services resources would have been committed to a range of projects within their analytical work programme, including a vast range of statistics published on a statutory basis via the Code of Practice for Statistics. However, many of these statistics were postponed due to the emerging situation, with it being impractical or inappropriate to continue with some data collections and other non-critical statistical work able to be paused. For example, the closure of schools made it impractical to collect data on attendance and teacher assessments. The collection of some data from local authorities was paused as it was considered inappropriate to divert local government resources towards this and away from the immediate pandemic response. This may not have been replicable in other emergency scenarios, where business as usual work would be expected to continue alongside the emergency evidence needs.

19. As a result, Knowledge and Analytical Services was able to move at pace to meet the early and rapidly evolving analytical needs that were emerging from the crisis. However, demand rapidly outstripped supply as the scope of the pandemic work expanded into wider areas during the spring and summer of 2020 (see paragraph 22 for further detail). As a result, it was accepted that further resources were needed to keep pace with the growing analytical demands, including, for example, leading the Welsh Government's contribution to the Office for National Statistics Covid-19 infection survey. Five new analytical posts were agreed by ExCo in June 2020 with an additional six posts agreed in November 2020. This was in addition to the demand for analysts to support the growth of the Technical Advisory Cell.

20. Arm's length bodies in Wales loaned four of their analysts to assist with the emergency response in the early stages of the pandemic. Loans from other departments (most notably the Office for National Statistics) also helped to bolster analytical resources. There was limited coordination at a UK level to address priority analytical resourcing needs. Attempts to make use of a centrally run Covid-19 deployment scheme from the UK Cabinet Office did not result in any additional analysts being placed with the Welsh Government.

21. Recruiting sufficient specialist resources (whether on a temporary or permanent basis) to meet the high demand for evidence was a constant challenge. This was particularly acute from late 2020 onwards, due to a combination of growing demands for Covid-19 related analysis, the return of some business-as-usual activities and burn-out experienced by analysts who had worked intensively on the early stage of the pandemic.

22. Despite significant redeployment of Welsh Government analysts and flexible use of resources, there were some projects that could not be adequately resourced due to a lack of capacity and capability. For example, the Technical Advisory Cell used an external organisation to produce and maintain an interactive dashboard of Covid-19 data which might otherwise have been delivered by Knowledge and Analytical Services and/or the Digital Data and Technology Directorate function if capacity were available. As demand often outstripped supply, priorities were regularly reviewed and agreed by the Knowledge and Analytical Services Covid-19 Senior Management Team (led by the Chief Statistician), with priority given to activities that only Knowledge and Analytical Services could and should do. The impact of managing priorities was that some activities progressed at a slower speed than I would ideally have liked. For example, there was substantial interest in using Care Inspectorate Wales data to regularly publish the number of care homes reporting Covid-19 cases. Preparing this data for publication for the first time had to be managed alongside a vast range of other activities (including maintaining the weekly publication on deaths in care homes), so it took longer to complete than if someone's time had been solely dedicated to this task.

Professional Standards and Leadership

23. The Code of Practice for Statistics is a statutory framework which sets the standards for producing official statistics in the UK. Welsh Government statistics adhere to the

principles and practices set out in the Code of Practice and, as Chief Statistician, I am responsible for the implementation of the Code. Further detailed standards for statistics in the Welsh Government are published openly on the Welsh Government's website, covering matters such as release practices, the handling of revisions or errors, and quality management.

24. The principles of the Code were applied, as far as were practicable, to the wide range of new statistics produced during the pandemic, even if they were not formally classed as Official Statistics.

25. Statisticians played a key role in advising on and upholding the standards of the Code of Practice for Statistics throughout the specified period. From the outset, Knowledge and Analytical Services sought to be transparent and keep users informed of the impact of the pandemic on statistical services. For example, changes to statistical plans were communicated openly through the Chief Statistician's updates on the Welsh Government's Digital and Data Blog. An example of such an announcement published on the Chief Statistician's blog is exhibited as **SH/05–INQ000271836**. The volume of new statistics published during the specified period also demonstrated a commitment to transparency in a way that sought to build trust in statistics and meet unprecedented user demand.

26. Over the course of the pandemic, statisticians moved at pace to acquire new data sources from within and outside the Welsh Government and published a wide range of new statistics. Although most of these new statistics were not formally badged as Official Statistics or National Statistics (now known as "accredited official statistics"), many of the same standards from the Code of Practice for Statistics on trustworthiness, quality and value were applied.

27. Given the value and public interest in very timely data, quality assurance processes were necessarily modified in order to provide appropriate assurance in the time available. Throughout the pandemic, statisticians drew on a range of official guidance on quality assurance, especially in the context of using the vast number of new, evolving data sources and the rapid turnaround times required. The UK Statistics Authority's guidance on Quality Assurance of Administrative Data and associated toolkit provided a framework for assessing the quality of new administrative data sources. The Office for National Statistics' Data Quality Hub also published advice during the pandemic on urgent quality assurance of statistical analysis and data. These

sources helped prioritise approaches to assurance when working at pace. In addition, the Statistical Quality Management Strategy sets out the Welsh Government's objectives on statistical quality and how these are implemented. Our quarterly Statistical Quality Committee was used to discuss the effect of the pandemic on statistical quality, to share best practice and consider how best to communicate quality issues. Over the course of the pandemic, committee agendas also featured items on specific sources which allowed more in depth discussion (for example, on new monthly management information on homelessness).

28. Within the Welsh Government, Knowledge and Analytical Services statisticians played an active role in promoting good practice and adherence to the Code of Practice. The Chief Statistician and other Knowledge and Analytical Services statisticians also worked closely with Care Inspectorate Wales to make the data it held about care homes available publicly. The impact of Covid-19 in care homes was a key topic of public interest, and thanks to the joint working of both Knowledge and Analytical Services and Care Inspectorate Wales, regular data on notifications of Covid-19 related deaths (and later, Covid-19 infections) was made available in the public domain from 5 May 2020. This data was also shared with the Office for National Statistics to support its work on mortality and care homes.

29. The Chief Statistician, as the leader of the official statistical system in Wales, played a proactive role in improving standards across a range of statistical producers during the specified period. There was a twice-yearly meeting of official statistics producers in Wales, which included a representative from Social Care Wales. Both Glyn Jones and I worked particularly closely with Public Health Wales on the implementation of standards from the Code of Practice, as Public Health Wales faced unprecedented public interest in their daily publication of statistics and did not have their own Head of Profession for statistics. This included offering advice on timing, frequency and communication of statistics and statistical quality, as well as connecting Public Health Wales with other statistical producers across the UK.

30. The Chief Statistician's role in the leadership and oversight of statistics in Wales was particularly highlighted in April 2020 when, following notification to the Welsh Government via Public Health Wales of under-reporting of Covid-19 related deaths by two local health boards in Wales, a review was conducted to obtain assurance of the reporting system. As a result of the review the then Chief Statistician was asked by the

First Minister to provide whole-system oversight of the reporting of rapid surveillance mortality data to Public Health Wales. A copy of the outcome of the review and agreed actions is provided in Exhibit **SH/06-INQ000066087**. In carrying out this role, the Chief Statistician applied the principles of the Code of Practice for Statistics and standards on Quality Assurance of Administrative Data. Following this review the Chief Statistician and the Medical Director for Public Health Wales co-chaired a rapid surveillance data oversight group. It was recognised the ONS data would be the comprehensive picture on mortality and the rapid surveillance data would not capture all deaths, including those in care homes, since data were primarily captured from hospital settings (see paragraphs 104-107). Following the review in April 2020, I recall a small number of further cases where some deaths were identified as having not been reported but I do not recall any further systematic under-reporting to the rapid surveillance data or any issues that specifically related to deaths in care homes.

31. Given the pace at which the Civil Service was working, there were inevitably some challenges in implementing the Code of Practice for Statistics. For example, it would not have been possible to carry out the same level of quality assurance that takes place outside of a time of crisis. Statisticians were pragmatic in their application of the standards set out in the Code and prioritised meeting user needs in a transparent way. Practical implications also needed to be considered, such as the best timings of statistical releases when the traditional 9.30am release time did not meet user needs (for example, to align with the public interest requirements of daily press conferences). For example, the Chief Statistician had to align some economic publications with the new Office for National Statistics release time of 7.00am and seek Office for Statistics Regulation approval for publication of other datasets like the Covid-19 Infection Survey at midday. I exhibit that at **SH/07–INQ000271837**.

32. The Chief Statistician advised Ministers and senior officials on several occasions on the proposed use of statistics that would normally be considered outside the standards set out in the Code of Practice. This usually involved exceptional use of unpublished data (for example in press briefings or the Senedd). In offering advice on this topic, the public value of using unpublished (or soon to be published) data was weighed against the potential impact on trust in statistics and trust in government.

33. Statistics in the Welsh Government are independently regulated by the Office for Statistics Regulation. Throughout the pandemic, the Office for Statistics Regulation

carried out a range of reviews and reports which include recognition of good practice by the Welsh Government and areas for improvement or future consideration. Independent assurance was sought from Office for Statistics Regulation on a number of new statistical developments, including plans to publish data on provision for children in local authority settings, which is attached as exhibit **SH/08–INQ000271840** and on new monthly indicators from the National Survey for Wales, which I exhibit at **SH/09–INQ000271841**. The Office for Statistics Regulation undertook rapid regulatory reviews on each of these, which included an assessment of the extent to which they met the standards of trustworthiness, quality, and value. On a relatively small number of occasions during the specified period the Office for Statistics Regulation made interventions on the use of statistics by the Welsh Government. Steps were taken to address the concerns raised on each occasion.

Statistical Publications

34. Statisticians in the Welsh Government published a substantial number of new statistical publications over the course of the pandemic in order to monitor trends and provide transparency on the data available. Some of the earliest statistical publications were related to hospital activity and care homes. It took a number of days and weeks to understand the demand for data, the insight required on NHS activity and care homes, and the regular cadence of press conferences and Ministerial statements. Once this was established, Knowledge and Analytical Services responded with new statistical publications. From April 2020 a weekly, and then daily, update of data related to NHS beds, admissions and hospitalisations was published in order to meet intense demand for this information. Data from Care Inspectorate Wales on deaths of care home residents began to be published from May and was later expanded to cover Covid-19 cases, as well as deaths.

35. In May 2020, the Welsh Government began publishing a statistical report on testing activity. The scope of this report grew and changed over time and came to include information on tests for some categories of key workers (including care home staff) and care home residents.

36. In August 2020, the Welsh Government published the first weekly results for Wales from the Covid-19 Infection Survey. The Welsh Government worked with the Office for

National Statistics on the development of the survey in Wales, following its launch in England in Spring 2020.

37. From May 2021, the Covid-19 interactive dashboard brought together in one place key statistics on Covid-19 along with a range of data that helped monitor a number of the harms related to the pandemic.

38. Statistical publications have varied in regularity of publication, with some daily, weekly, fortnightly and others monthly. This was a marked shift from pre-pandemic statistical practices, where most publications were quarterly or annual. The frequency of any individual publication has varied over time, mirroring the trajectory of the pandemic and the public interest in the topic.

39. The user need for statistical information and future plans for publication were considered as part of the Covid-19 transition plan and a blog post outlining publication plans was published in April 2022. Some outputs continued on their existing basis, others became less frequent, and others stopped altogether. In relation to adult social care, the blog post noted that Care Inspectorate Wales datasets would continue to be published, but the written reports that accompanied them would reduce in frequency.

40. The Office for Statistics Regulation expects that public statements made by Ministers are based on statistics and data that are equally available to all. Statisticians worked with communications teams and special advisers to provide quality assurance of data used in Ministerial statements. Slides for the regular Welsh Government televised press briefings were usually produced by statisticians to ensure that they were based on publicly available sources, and that messages were communicated accurately and clearly. The source of any data used was clearly noted on the slides. Following an intervention from the Office for Statistics Regulation, all press conference slides were published on the Welsh Government website from December 2020. Two examples of slide sets are exhibited at **SH/10-INQ000388303** and **SH/11-INQ000090690** both of which use data from Public Health Wales on the vaccination of care home residents.

41. Responses to any ad-hoc requests are published on a fortnightly basis, so that the information is available to be re-used by others. During the specified period this was used where necessary to put previously unpublished data into the public domain if it was used in a public statement, or where there was public interest in doing so.

42. Chief Statistician's updates on the Welsh Government's Digital and Data blog were also used throughout the relevant period to provide independent expert analysis and discussion on statistical matters. Blog posts have been used to communicate changing statistical priorities and workplans as the course of the pandemic evolved. The blog has also been used to offer explanation and insight on statistical issues where there was the potential for confusion or misuse. Examples include explaining the sources of mortality data exhibited at **SH/12-INQ000513658**, and how to understand infection rates in the light of changes to testing policy, exhibited at **SH/13-INQ000271843**. The blog has regularly been praised by the Office for Statistics Regulation as a good practice example of clear, transparent communication.

Engagement with Stakeholders Regarding Adult Social Care

43. The following sections set out the high-level engagement arrangements with stakeholders related to adult social care during the pandemic period. There was no engagement with international organisations on this topic throughout this period.

Welsh Government Ministers and Officials

44. Statisticians engaged with Welsh Government Ministers and officials (including Senior Civil Servants) in a variety of ways throughout the pandemic period. Statisticians were involved in many of the Covid-19 response structures (these are mentioned throughout this statement) and used their membership of these groups or their existing relationships with policy officials to identify analytical requirements and to take commissions. The Covid-19 analysis hub also acted as a point of commissioning and received requests for new analytical work.

45. The Chief Statistician was invited to give a weekly update to the Permanent Secretary and Directors General at ExCovid, drawing on the latest data from the Covid-19 data monitor which was produced by Knowledge and Analytical Services (the data monitor is discussed later in this statement). A statistician also presented the latest trends from the data monitor at the Covid-19 Preparedness Bird Table which was an informal information sharing forum for Welsh Government policy officials. Attendance at both

ExCovid and the Bird Table allowed statisticians to identify new opportunities to inform the work of policy teams. The remit of these groups considered all elements of the pandemic response, including adult social care.

46. Statisticians also provided regular and frequent written briefings to Ministers and officials on data and statistics, as well as taking direct commissions for analysis. Briefings were provided on both the data held by the Welsh Government and on statistics produced by other government departments, most notably those produced by the Office for National Statistics. Verbal briefings were also provided to Ministers, especially where new statistics were produced or professional advice was needed to interpret data (for example, in the early days of the vaccination roll out). Sometimes this would be requested as part of regular meetings policy officials had with Ministers, for example on Test, Trace, Protect or vaccinations. Other times requests for verbal updates would be ad hoc. Neither Glyn Jones nor I met with a Minister to discuss adult social care statistics, although analysis from the Social Care Checkpoint (which is explained at paragraphs 71 to 75 of this statement) was regularly shared with Ministers. The Chief Statistician also met regularly with the Chief Medical Officer to brief him on latest statistical developments. These were informal meetings without minutes. Data on care homes may have been discussed, but neither Glyn Jones nor I recalls any specific instance of briefing the Chief Medical Officer on adult social care.

47. Statisticians were members of the Covid-19 Intelligence Cell, which helped to ensure that the latest data fed into intelligence gathering and decision-making, and that it was interpreted correctly (for example, in the compilation of the Covid-19 Situational Reports which was led by the Technical Advisory Cell). This included the use of data from Care Inspectorate Wales on Covid-19 cases and deaths in care homes, alongside other intelligence on care homes gathered by other Intelligence Cell members.

48. As well as the mechanisms set out above, statisticians used existing relationships with policy officials on social care to understand and meet their analytical requirements. This is how the requirement for the Social Care Checkpoint data collection came about, which is discussed later in this statement.

The Technical Advisory Cell and Technical Advisory Group

49. The Technical Advisory Cell was a key user of the data and statistics produced by Knowledge and Analytical Services. Knowledge and Analytical Services officials met regularly with officials from the Technical Advisory Cell in order to share plans and priorities and identify new data requirements. The Chief Statistician was a member of the Technical Advisory Group and statisticians sat on a number of its sub-groups. This enabled statisticians to provide professional statistical advice, as well as understand their requirements for further analysis.

    During Spring 2020, it became clear through the Technical Advisory Group and discussions outside the group that numerous parties were working on similar areas of interest on care homes, including Knowledge and Analytical Services, Public Health Wales and Swansea University's SAIL Databank. Glyn Jones proposed that it would be beneficial to bring together this activity into a single group to coordinate the work. This was taken forward by an official in social services policy. The Residential Care Covid-19 Research and Analysis Group was established and Knowledge and Analytical Service statisticians took part in this group. The terms of reference for this group from 5 August 2020 are exhibited at **SH/14-INQ000539024**. I have been asked if nursing homes were within the remit of the group. The terms of reference do not explicitly refer to whether nursing homes were in or out of scope, and as I was not personally a member of the group I cannot provide confirmation on this matter.
50. Estimates of the number of vulnerable adults (which included people receiving domiciliary care and people recorded on disability and dementia registers) were presented by statisticians to the Technical Advisory Group in October 2020.

51. Knowledge and Analytical Services did not engage directly with SAGE or other UK scientific groups. This relationship was instead managed through the Technical Advisory Cell.

Public Health Wales and the NHS in Wales

52. Prior to the pandemic, there was not a close working relationship between Knowledge and Analytical Services and Public Health Wales, particularly with the surveillance team in Public Health Wales. Yet this proved to be one of the most important relationships over the period of the pandemic as many of Public Health Wales

surveillance datasets were being used daily to monitor and inform the pandemic response. There were frequent ad hoc meetings between Knowledge and Analytical Services and Public Health Wales throughout the pandemic to discuss these datasets. As described in paragraphs 29 and 30, the Chief Statistician also worked closely with Public Health Wales on the application of the Code of Practice for Statistics and on the assurance of mortality data.

53. Specifically in relation to adult social care, Knowledge and Analytical Services, the Technical Advisory Cell, Public Health Wales and Care Inspectorate Wales met regularly to understand and share knowledge on the range of data sources on care homes. Public Health Wales held data in its Tarian system (an incident and case management system which supports surveillance activity on a range of communicable diseases) on Covid-19 outbreak incidents in care home settings, which we were keen to compare to data from Care Inspectorate Wales and the Office for National Statistics. At times in 2020 there were weekly meetings to discuss this data where I and colleagues requested that the data be shared with us in order to facilitate this comparison. Public Health Wales was reluctant to share this information, potentially due to concerns regarding its quality, and reported that it was seeking senior approval to share it. Despite these multiple requests, I do not recall my team receiving a regular supply of this data from Public Health Wales, although I understand an extract was supplied to the Chief Medical Officer after he wrote to Public Health Wales on this matter. I do not know if regular updates to this data extract were supplied or if it was a one-off data share.

54. In terms of engagement with other NHS in Wales organisations, Knowledge and Analytical Services shared data from the Social Care Checkpoint with the NHS Delivery Unit to inform its modelling analysis. Knowledge and Analytical Services did not engage directly with health boards regarding adult social care.

Official statistics producers across the UK, including the Office for National Statistics

55. The Concordat on Statistics, which I exhibit at **SH/15-INQ000335482** sets out the framework for cooperation between the four nations of the UK on statistical matters. The Inter-Administration Committee – a meeting of the UK's National Statistician and Chief Statisticians in Wales, Scotland and Northern Ireland – promotes coherence across the four nations. As a long established part of the Government Statistical

Service governance structure, this group continued to meet quarterly throughout the pandemic. There were regular agenda items from July 2020 onwards which included mention of the coherence of statistics on social care across the UK, in particular, on deaths in care homes. As an example I exhibit the Inter-Administration Committee papers from its meeting on 14 April 2022, at **SH/16-INQ000513718**.

56. A statistical Four Nations Adult Social Care Group met for the first time in February 2020 and continued to meet every two to three months throughout the pandemic period. The aim of the group was to share relevant work and learning, develop a better understanding of the landscape of adult social care data across the four nations and discuss the extent of comparability of data. Each meeting had a round table session where members updated others in relation to relevant recent and upcoming work, which included Covid-19 related activities. Membership of the group included analysts from the Welsh Government, Scottish Government, Department of Health and Social Care Northern Ireland, NHS England, UK Department for Health and Social Care, and the Office for National Statistics. I exhibit at **SH/17-INQ000513657** the proposal for the establishment of the group, and I exhibit as an example the minutes from the June 2020 meeting at **SH/18-INQ000513650**.

57. Throughout the course of the pandemic, I do not recall any direct engagement on adult social care with Public Health Scotland, NHS Scotland health boards, National Records Scotland or the Public Health Agency for Northern Ireland (although in some cases there was engagement on statistical matters outside of adult social care).

58. The Office for National Statistics was responsible for a range of pandemic-related statistics for Wales, most notably mortality data. Knowledge and Analytical Services, Public Health Wales, the Office for National Statistics and statisticians from other UK nations met regularly throughout the pandemic to coordinate work in this area. The inclusion of care home deaths in the Office for National Statistics' analysis of COVID-19 deaths was first discussed in this group on 2 April 2020. The Office for National Statistics regularly responded to data requests from the Welsh Government on mortality (for example, deaths of social care workers, which is discussed later) which helped to monitor the impact of the pandemic. There was also regular engagement on the development of the Covid-19 Infection Survey, through regular working level contact and as part of the governance arrangements for the surveys. The survey development was an example of good collaborative working across the UK statistical system at a time of national crisis.

UK Government

59. From late March 2020, Knowledge and Analytical Services led engagement with the UK Government's Civil Contingencies Secretariat on data-related matters. This included coordinating a number of 7-day-a-week data returns to the UK Government and the Department for Health and Social Care. The largest of these was the daily return used to populate the UK Government's internal Civil Contingencies Secretariat dashboard. The dashboard had a very senior audience in the UK Government and was used extensively in the Welsh Government in the early months of the pandemic, before products such as the data monitor became established.

60. The scope of the daily dashboard return was varied and grew considerably over time. It initially covered topics such as testing, cases, deaths, ventilators and hospital activity. It grew to include a range of metrics on care homes, staff absence, shielding, food parcels, school attendance, cancer referrals and more. Specifically in relation to social care, data was requested on the size of the care home population "at risk", the number of Covid-19 cases and live outbreaks in care homes, deaths in care homes, information on personal protective equipment supply and care home staff absence. It took considerable effort to understand the definitions that should be used in the data returns, identify appropriate data sources, collate the data into a suitable format and quality assure the content.

61. The Civil Contingencies Secretariat regularly requested new data items, some of which were not always readily available for Wales, with many of the social care items falling into this category. This included data on live care home outbreaks, the size of the care home population and care home staff absence. A steer was sometimes sought from senior officials, special advisers and Ministers on whether to agree to new requests (in the context of prioritising our scarce analytical resources) but generally officials looked to work positively with the Civil Contingencies Secretariat and provide data where it was available and could be accommodated alongside other priorities.

62. Engagement with the Department for Health and Social Care on adult social care was largely through the Four Nations Adult Social Care Group described above. There was regular engagement with Public Health England (and then UK Health Security Agency) but this was not generally in relation to adult social care.

63. Liaison with the Joint Biosecurity Centre was mostly led by the Technical Advisory Cell. I occasionally attended working level four nations meetings and "show and tells" with the Joint Biosecurity Centre to identify opportunities for learning and collaboration. These meetings covered a broad range of activities and projects, and it is likely that this would have included social care, but I cannot recall with certainty that this was the case.

Data Collection and Data Sharing

Suspending Data Collections

64. Paragraph 18 refers to the decision in April 2020 to pause some statistical data collections from local authorities. The Ministerial Advice on this decision, exhibited at **SH/19-INQ000116609**, sets out the reasons for the decision, which included the degree of disruption to data collection processes, plus ensuring resources (both within local authorities and the Welsh Government) could be directed at the highest priorities. In developing these proposals, policy officials were consulted, as well as local authorities and there was general support for the proposed approach.

65. For adult social care, the following aggregate data collections were suspended.
    a. Adults receiving care and support 2019-20
    b. Adult safeguarding 2019-20
    c. Staff of local authority social services departments 2019-20
    d. Disability registers 2019-20

66. A Chief Statistician's blog was issued on 1 June confirming that many data collections had been suspended as a result of Covid-19. The Chief Statistician also wrote to local authority chief executives, the Welsh Local Government Association and Data Cymru to inform them of the suspension of data collections. **I exhibit the letter at SH/20-INQ000513656.**

67. The affected social services data collections were either reinstated for 2020-21 (in the case of disability registers) or evolved into new data collection arrangements aimed at improving data on the social care sector. These were plans which pre-dated the

pandemic and were in response to the introduction of the new code of practice in relation to performance and improvement of social services in Wales, which was issued on 1 April 2020.

Data Acquisitions

68. Two major sources of data in relation to adult social care were acquired and used by Knowledge and Analytical Services throughout the pandemic period. These were data from Care Inspectorate Wales on notifications of Covid-19 cases and deaths, and a new data collection from local authorities known as the Social Care Checkpoint.

Care Inspectorate Wales Notifications Data

69. From late April/early May 2020, daily management information was obtained from Care Inspectorate Wales on the notifications they received regarding Covid-19 cases and deaths in care homes. The Chief Statistician and other Knowledge and Analytical Services statisticians worked closely with Care Inspectorate Wales to make the data it held about care homes available publicly. The impact of Covid-19 in care homes was a key topic of public interest, and thanks to this joint working, regular data on notifications of Covid-19 related deaths (and later, Covid-19 infections) was made available in the public domain from 5 May 2020. Analysis of this data was included in the data monitor and the data also shared with the Office for National Statistics to support its work on mortality and care homes. A summary of the trends in the Care Inspectorate Wales data is provided in paragraphs 118-123. Further detail on sharing the data with the Office for National Statistics is described in paragraph 112.

70. The data was classed as management information rather than Official Statistics. The data was collected primarily to inform the Care Inspectorate's regulatory activities and decisions, and to enable it to monitor care homes with outbreaks of Covid-19. It was therefore not collected for statistical purposes and data quality was reliant on registered care providers reporting consistently and accurately. However, the data provided a reasonable quality and timely indicator of trends on Covid-19 in care homes.

Social Care Checkpoint

71. Prior to the pandemic, official statistics on social services activity were typically collected and reported on an annual basis, however the pandemic brought about the need for more timely information. A policy official in social services had originally sought to collect some information from local authorities through a questionnaire, however there was a desire to collect more regular data and intelligence in a systematic way. Knowledge and Analytical Services worked with policy officials and a specialist policy adviser to design and implement a data collection which gathered rapid monitoring information on local authorities' ability to provide social services during the pandemic period.

72. The new data collection, the Social Care Checkpoint, was put in place in May 2020, following a period of engagement with local authorities and Directors of Social Services (this latter engagement was led by the Chief Social Care Officer). In general, local authorities supported setting up the new data collection, so that any issues with delivering social services during this period could be monitored by the Welsh Government. Weekly collections were set up for adult services, children's services and workforce. This allowed local authorities to report timely information on the volume of activity and rate their capability to undertake key functions. Copies of the data collection forms are exhibited (at **SH/21-INQ000513652**), with examples provided to show how the content of the form evolved over time:
    a. Adult services collection from 4 May 2020 – the first data collection
    b. Adult services collection from 21 June 2021
    c. Adult services collection from 13 June 2022
    d. Workforce collection from 11 May 2020

73. Many of the data items collected were in the form of a red/amber/green delivery status. Statisticians recognised that there was a degree of subjectivity in deciding which status a local authority should choose. There were also some occasional challenges with receiving regular returns from all 22 local authorities, given the weekly frequency of the request. However, the Checkpoint was broadly judged to be a successful method for gathering timely intelligence from local authorities and monitoring the improvement or deterioration of trends.

74. The data was collected from May 2020 to May 2021 weekly, then fortnightly from June 2021 to March 2022. It was collected monthly from May 2022. In January 2022 some

of the data items changed to better reflect the evolving situation of the pandemic and needs for data. In November 2022, there was a review of the data collection and large-scale changes were made. The revised collection has continued on a monthly basis.

75. Summaries and spreadsheets of the Checkpoint data were produced by Knowledge and Analytical Services. These were shared with the Social Services Improvement division to disseminate to relevant Welsh Government policy officials, the Chief Social Care Officer, Ministers and other Cabinet Members, local authority Directors, Care Inspectorate Wales and Social Care Wales. The data was used by policy officials to assess whether any local authorities needed additional support during this time. Data was also shared with the NHS Delivery Unit (to undertake sufficiency modelling to see whether there was enough capacity to respond), as well as with members of the Technical Advisory Cell. Some short summaries were also included in the Covid-19 data monitor.

Data Sharing

76. In general, there was a willingness across the public sector and beyond to supply or share data to support the pandemic response. As reported above, local authorities were supportive of the development of the Social Care Checkpoint, and Care Inspectorate Wales made its data available for use beyond its own immediate purposes. This included sharing the Care Inspectorate data with the Office for National Statistics (discussed later). There are many other examples from across the pandemic not specifically related to social care that also demonstrate this willingness to share in order to support the response to Covid-19. This includes the Office for National Statistics making the 2011 Census data available in the SAIL Databank for the first time, a significant milestone which facilitated a range of academic research related to Covid-19 and beyond.

77. The biggest challenges were in situations where existing relationships were fairly nascent. As described earlier in this statement, there was not a close working relationship between Knowledge and Analytical Services and the surveillance team in Public Health Wales. It was challenging to develop the timely appropriate flows of data in the right format to support the analytical work of Knowledge and Analytical Services. This led to significant manual work across the system, such as being unable to access a feed of raw data on testing and therefore Public Health Wales providing an extract

for Knowledge and Analytical Services on a regular basis to enable production of the official statistics outputs.

78. Different priorities across different organisations could also lead to difficulties. For example, with Public Health Wales focused on using data for surveillance purposes, it was often not a priority of theirs to support responses to media requests, or Ministerial briefings, whereas statisticians in the Welsh Government were being asked to urgently provide the data to support such situations.

79. Paragraph 53 of this statement refers to an example where data related to care homes was not shared. In this instance, I believe Public Health Wales's motivation was to ensure the data was used appropriately, given potential quality concerns. However this resulted in missed opportunities to compare with other data sources, so I cannot know if the data would have provided additional insight compared to the information that was available from Care Inspectorate Wales and the Office for National Statistics.

Data Analysis

The Covid-19 Data Monitor

80. The Covid-19 data monitor was a regular compendium of data and charts produced by the Covid-19 Analysis Hub in Knowledge and Analytical Services. The first data monitor was produced and circulated on 3 April 2020, following a discussion at the Covid-19 Preparedness Bird Table about the need for a single document of key information and graphs. The frequency of the data monitor changed over the course of the pandemic but was typically produced weekly for most of the pandemic period. Three examples of the data monitor are exhibited, to demonstrate the evolution of the document. These are from 4 June 2020 (**SH/22-INQ000129879)**, 14 December 2020 (**SH/23-INQ000129906**) and 11 January 2021 (**SH/24-INQ000057769**).

81. The format and content of the monitor was decided by officials in Knowledge and Analytical Services, with input from the Covid-19 Preparedness Bird Table. The monitor was not intended to provide comprehensive coverage of every data source available. Instead, each theme was curated to provide a well-rounded assessment of key topics based on available data, with timely insight being prioritised over more lagged data sources. The earliest versions of the monitor mostly focused on data from

Public Health Wales, Digital Health and Care Wales and public sector management information, but the content was expanded over time to include a wider range of topics.

82. The following topics related to adult social care were regularly included in the data monitor.
    a. Care homes with cases of Covid-19, from Care Inspectorate Wales data: this was initially presented as the cumulative percentage of adult care homes that had reported a confirmed case of Covid-19. This data became less useful over time as more care homes reported cases, so around December 2020 it was instead changed to care homes that had reported cases over a set period of days (e.g. over the last 7 days or the last 20 days). This change improved the relevance of the data and allowed trends to be monitored over time. The data quality for confirmed cases of Covid-19 is likely to have improved in line with the availability of tests. On some occasions, local authority breakdowns were included in the data monitor.
    b. Domiciliary care services reporting cases of Covid-19, from Care Inspectorate Wales data: as with the early care homes data, this was presented as a cumulative percentage of the number of services reporting a Covid-19 case. This was removed from the data monitor after 14 December 2020. The reason for this is not recorded but was likely due to the quality of the data or the limited use that was being made of it.
    c. Notifications of deaths in care homes, from Care Inspectorate Wales data: this was initially presented as the total number of notifications compared to the previous two years. Over time it evolved to be presented as the rolling 7-day-average of the number of care home service user deaths notified to Care Inspectorate Wales, including a breakdown for Covid-19 related deaths.
    d. Social Care Checkpoint summaries: the data monitor included a Wales-level summary of local authority adult social services departments' ability to operate, based on a red/amber/green status. The assessment covered whether the department had enough staff to operate and had the capability to place adults with a care and support plan in appropriate residential care settings. It included the latest position and a comparison with the previously reported period. This information was included in the monitor until 7 December 2020, after which point it was removed. (A range of other data items were also removed around this time as part of a regular review of content.)

83. The data monitor regularly included summaries of Office for National Statistics mortality data, which included place of death (of which "care homes" was one category). The monitor also included summary information on personal protective equipment supplies, but not specifically in relation to social care.

84. On 19 April 2021, the Covid-19 in Wales interactive dashboard was published on the Welsh Government website. This began to replace the internal data monitor. The decision to replace the monitor with a public dashboard followed a light-touch review by Knowledge and Analytical Services officials of a number of Covid-19 compendium data products and dashboards. This identified that there was no single coherent public-facing overview of the key Covid-19 data in Wales which brought together monitoring data on direct Covid-19 harms, indirect harms, and social and economic impacts (in the same way that the data monitor did for an internal audience). As most of the well-used data sources from the monitor were at that point in the public domain, the decision was made to transition the monitor to a public facing dashboard. This was considered to be in line with the principles of the Code of Practice for Statistics as it ensured greater transparency of the data used to support decision-making. I exhibit **SH/25-INQ000508494** which is a copy of the first interactive dashboard from 19 April 2021, and **SH/26-INQ000513719** which is a copy of the dashboard from 31 August 2021 when data from Care Inspectorate Wales were first included.

85. The format of the dashboard differed from the monitor – it was an interactive dashboard, rather than the static slide pack used for the monitor. With the transition to the dashboard, the opportunity was also taken to review and rationalise the content of the data monitor and as a result some topics were removed. These were either where data could not be shared outside government or where the topic was no longer considered relevant or high profile.

86. The interactive dashboard was developed in a phased way, with more topics added over time. From 31 August 2021, the Care Inspectorate data on notifications of Covid-19 cases and deaths was included in the interactive dashboard. During the transition to the interactive dashboard, some small parts of the original data monitor were retained and continued to be circulated internally, which included the Care Inspectorate data.

87. The monitor was circulated to Ministers, the Chief Medical Officer, officials in the Technical Advisory Cell and a large number of other officials (including some Senior

Civil Servants with responsibility for social care). The monitor was regularly tabled at Cabinet, although the Chief Statistician and other statisticians did not attend Cabinet. As mentioned previously in this statement, it was presented at ExCovid and the Covid-19 Preparedness Bird Table. The monitor was also shared with Police and Crime Commissioners and the Joint Military Command Wales Intelligence Cell, with any data that could not be shared outside the Welsh Government removed.

Retrospective Analysis of Testing Prior to Discharge to Care Homes

88. From mid-May 2020, significant interest emerged in the discharge of patients from hospitals to care homes during the early period of the pandemic. This resulted in a number of written questions from Senedd members and media queries, and data were being pulled together in a piecemeal fashion. The written questions were published on the Senedd website and an example of which is set out in exhibit **SH/27–INQ000271827**. Due to this increasing public interest and the importance of developing a coherent understanding of discharges, during this time the Director General for Health and Social Services and the Chief Statistician agreed it would be beneficial to pull together a full and coherent analysis of care home discharges and testing, between March and May 2020.

89. The data required to support an understanding of testing prior to care home discharges and subsequent outcomes were not available in one place. As far as Welsh Government analysts were aware, this work had not previously been undertaken, although we cannot advise on whether previous work had taken place within the NHS. It required analysis across the Admitted Patient Care dataset and the Laboratory Information system (both held by the NHS Wales Informatics Service). In June 2020, the NHS Wales Informatics Service was requested to pull together a full data set consisting of discharged patients, their Covid-19 testing status, and whether they had subsequently died (using Office for National Statistics data). This required the NHS Wales Informatics Service to link records together from at least three different data sources by using NHS patient numbers. The data covered all available records up to the point the data was extracted on 30 June 2020. Given the complexities of the analysis and the reliance on management information, there was a degree of iteration and continuous improvement in the methodology, as well as updates as data extracts were refreshed. This is highlighted in the comparisons between answers provided to written statements and the final product described below.

90. The dataset enabled statisticians to examine at a patient level the specimen date of the test, authorisation date, test result, the order in which tests were taken and the number of days before or after discharge the test was authorised. The analysis was produced by Knowledge and Analytical Services in June and July 2020, and a draft was shared with key officials in the Welsh Government and the Technical Advisory Cell. A final version of the report was circulated to Ministers, senior officials, and special advisers in July 2021, I exhibit this at **SH/28–INQ000271757**.

91. The main findings from the analysis were:

    a. The number of discharges from hospital to care homes were higher in March 2020 than in each of the two previous years. The opposite was true for April and May 2020, when discharges from hospital to care homes were lower than the two previous years. This is likely to reflect that during March 2020 discharges were unusually high as hospitals were preparing for the early impact of Covid-19 and trying to increase capacity.

    b. The share of people who were tested for Covid-19 prior to discharge to a care home increased over time, with a large increase seen in the week the guidance on testing changed (week commencing 27 April 2020). In March 2020, 96% of discharges to care homes did not have a recorded test. This fell to 65% in April prior to the guidance change. After the guidance change, 9% of discharges in April did not have a test recorded and 11% in May (47 discharges in total).

    c. From 1 March 2020 to 31 May 2020, 637 patients were tested at any point prior to discharge. 26% (168 out of 637) received a positive result. This includes patients that were tested in hospital or at any point before admission. Of the patients who tested positive prior to discharge, 65% (110 out of 168) were discharged more than 15 days after receiving a positive test. Where there was a positive test within 7 days prior to discharge, the majority occurred prior to the change in policy guidance on 29 April 2020.

    d. Of the 81 discharged patients to care homes who, by the point of data extraction on 30 June 2020, had died of Covid-19 related causes, 62 hadnot received a test in hospital prior to discharge. The majority of those who did not receive a test were discharged in March 2020. From the week commencing 27 April 2020 all patients discharged who later died of Covid-19 causes had received a test prior to discharge.

92. Although this is not explicitly mentioned in the report, it is important to consider the impact the methodology could have had on the findings. After the guidance change, the analysis showed that there remained a small number of records of a discharge to a care home that were not matched to a testing result (47 in total). This could genuinely mean that no test was carried out, but we cannot rule out that this could be an artefact of the data linking methodology where a successful link between records might not have been made even though a test may have been completed.

93. When sharing the final report in July 2021, statisticians advised that the report should remain as internal analysis for two reasons (although this should be revisited if there was renewed interest in the topic):
    a. The pertinent information had already been made available in answers to written questions from Senedd Members and in response to media enquiries. It was therefore felt to offer limited additional public value.
    b. Research by Public Health Wales and Swansea University Medical School had been published since the analysis was started which provided a more comprehensive account of risks factors and outbreaks in relation to discharges from hospital to care homes. I exhibit that analysis at **SH/29–INQ000271828.**

94. The analysis from Public Health Wales and Swansea University, published in February 2021 and exhibited in the above paragraph, looked at risk factors for outbreaks of Covid-19 in care homes following hospital discharge. It used different methods and examined a longer time period for discharges than the analysis produced by Knowledge and Analytical Services (from 22 February to 27 June 2020, compared to 1 March to 31 May 2020). It also considered wider factors that were not investigated in the analysis produced by Knowledge and Analytical Services, such as care home size and the type of service provided (e.g. with or without nursing care). Public Health Wales and Swansea University found that large care homes were at considerably greater risk of outbreaks throughout the pandemic. The number of residents who had been discharged to a care home from hospital was not associated with a significant increase in risk after adjusting for care home size.

Other Ad Hoc Analysis

95. The spreadsheet exhibited later in this statement includes a full list of analysis related to social care that was carried by Knowledge and Analytical Services over the course of the pandemic.

96. Prior to the first national lockdown in March 2020, Knowledge and Analytical Services was supporting key decision-makers with analysis to support their understanding of the impact of non-pharmaceutical interventions. The Chief Statistician was invited to one of the first preparedness meeting with senior officials on 6 March 2020, and immediately engaged over the weekend of 7-8 March with input from economists to provide supporting analysis on the emerging proposals around non-pharmaceutical interventions. This initial work was in response to wider UK civil contingencies requests for supporting evidence around the impact of non-pharmaceutical interventions on people, families, and public service delivery. The analysis produced included descriptive statistics such as population estimates by age, numbers of carers, numbers receiving social care and the social care workforce. Further analysis was also provided on potential economic and public service impact of different non-pharmaceutical interventions. These are exhibited at **SH/30–INQ000271855** and **SH/31–INQ000271853**. This was summarised and submitted to the UK Civil Contingency Secretariat. **SH/32-INQ000352954**, **SH/33-INQ000352956** and **SH/34-INQ000352958** show the relevant documents

97. Other early analysis to support the pandemic response focused on industry and occupation, in order to understand the impact of measures on particular sectors. Knowledge and Analytical Services used Office for National Statistics statistical surveys such as the Annual Population Survey to produce estimates on topics such as the number of people working in specific occupations or industries, numbers of key workers, protected characteristics of workers, long term illness of workers and people working in high-risk occupations. Some of these requests were specifically in relation to social care. Others covered a wide range of sectors, of which social care was one.

Covid-19 Infection and Mortality Methods

98. The Office for National Statistics and Public Health Wales produced the main sets of statistics used to monitor Covid-19 infection and mortality over the course of the pandemic. Knowledge and Analytical Services regularly used these sources but were not responsible for producing them.

Covid-19 Infection

99. Rapid surveillance data from Public Health Wales was the timeliest source for monitoring Covid-19 infection. This information was produced daily by Public Health Wales using testing data from the Welsh Laboratory Information Management System. The Covid-19 Infection Survey, produced by the Office for National Statistics, was the second main source of data on Covid-19 prevalence in Wales. The survey provided a weekly estimate of Covid-19 prevalence.

100. The data from Public Health Wales was very timely and therefore provided rapid insight on Covid-19 case rates, whereas the survey data from the Office for National Statistics had a lag of around a week. But the Infection Survey benefited from being a random sample survey and was therefore not affected by changes in testing policy and behaviour in the same way that rapid surveillance data was. Generally, the two sources provided a well-rounded picture of Covid-19 prevalence and followed similar trends.

101. The Covid-19 Infection Survey aimed to track the extent of infection in the community population. It therefore included people in private residences (including the adult social care workforce and care recipients living in private residences), but did not include people in communal establishments such as care homes or hospitals. The Public Health Wales data included all tests that were carried out, regardless of whether they were in the community, communal establishments or from other locations. The Office for National Statistics produced some analysis from the Infection Survey on people testing positive by occupation, which included caring occupations, but as far as I can recall this analysis did not provide figures for Wales.

102. In England, the Department for Health and Social Care commissioned the Office for National Statistics (in partnership with Ipsos MORI, University College London and Public Health England) to undertake the Vivaldi project. This was a study to measure the prevalence of the Covid-19 in care homes and the use of disease control measures. An equivalent study was not commissioned in Wales, although the availability of a large number of datasets in the SAIL Databank facilitated some similar analysis, such as that described in paragraph 94 on the factors related to outbreaks in care homes.

Covid-19 Mortality

103. There were generally two main sources of data for Covid-19 mortality during the relevant period. Firstly, the rapid surveillance data around deaths collected by Public Health Wales via their e-form and published on a daily basis. Secondly, data regarding deaths, as ascertained from death certificates where Covid-19 was mentioned, published weekly by the Office for National Statistics.

104. Public Health Wales data was designed to rapidly identify trends in mortality; it was not intended to be used as a complete and accurate source of all deaths as it largely focused on deaths in hospitals. It is acknowledged that whilst it may have captured some deaths in care homes (and of care home residents), it would not necessarily have captured them all. It was therefore not the authoritative source on mortality in care homes.

105. The data from the Office for National Statistics intended to capture all deaths, including those occurring in care homes, and throughout the pandemic. This data was considered the authoritative picture of Covid-19 mortality. Mortality data was published by the Office for National Statistics on a weekly basis and would regularly include a breakdown of data by place of death (e.g. hospital, care home, private home). Through the ONS data, we could measure the number of deaths that took place in care homes, but it did not tell us if a care home resident subsequently passed away in hospital after being infected with Covid-19. To address this, ONS also produced estimates of deaths of care home *residents*, regardless of the setting in which the death occurred.

106. A search of the Office for National Statistics published statistics shows that it began publishing weekly data on Covid-19 related deaths on 31 March 2020, which captured deaths registered up to the week ending 20 March 2020. Information on Covid-19 related deaths was not published by Office for National Statistics prior to this date, but data on deaths from all causes was available.

107. The Office for National Statistics broke down mortality data by place of death in its publications from 7 April 2020, which captured deaths registered up to the week ending 27 March 2020. It also periodically published analysis of deaths of health and

care workers, and deaths of care home residents who may have died in a care home, hospital, or elsewhere.

108. I have been asked to comment on the methodology for mortality data. I do not have detailed working knowledge of how death registration data is accessed by the Office for National Statistics, its completeness, the details of how cause of death is coded, its underlying limitations or the quality checks completed. However, the Office for National Statistics has transparently published a wide range of material on the quality of mortality statistics and the methods used. This includes the use of international classifications for coding cause of death. As mortality statistics are an Official Statistic, the Office for National Statistics would apply the standards from the Code of Practice for Statistics and is regulated by the Office for Statistics Regulation, which provides a high degree of assurance on their quality.

109. I understand Office for National Statistics mortality data to be a complete record of all deaths that had been registered by the stated reference period, regardless of where they occurred. In terms of cause of death, in the early days of the pandemic, when clinicians may have been less familiar with the symptoms of Covid-19 and testing was less widespread, I understand it may have been less likely that Covid-19 was recorded as a cause on the death certificate, however the death would still have been recorded.

110. In addition, specifically in relation to care homes, the Welsh Government utilised management information available from Care Inspectorate Wales. As a regulator, Care Inspectorate Wales received notifications of deaths of care home residents. Knowledge and Analytical Services and Care Inspectorate Wales commenced publication of this data from 5 May 2020. An important difference between the sources in relation to Covid-19 deaths is that the Office for National Statistics reported deaths where Covid-19 was mentioned on the death certificate, whereas the Care Inspectorate notifications rely on the statement of the care home provider that Covid-19 was suspected or confirmed.

Care Home Definitions

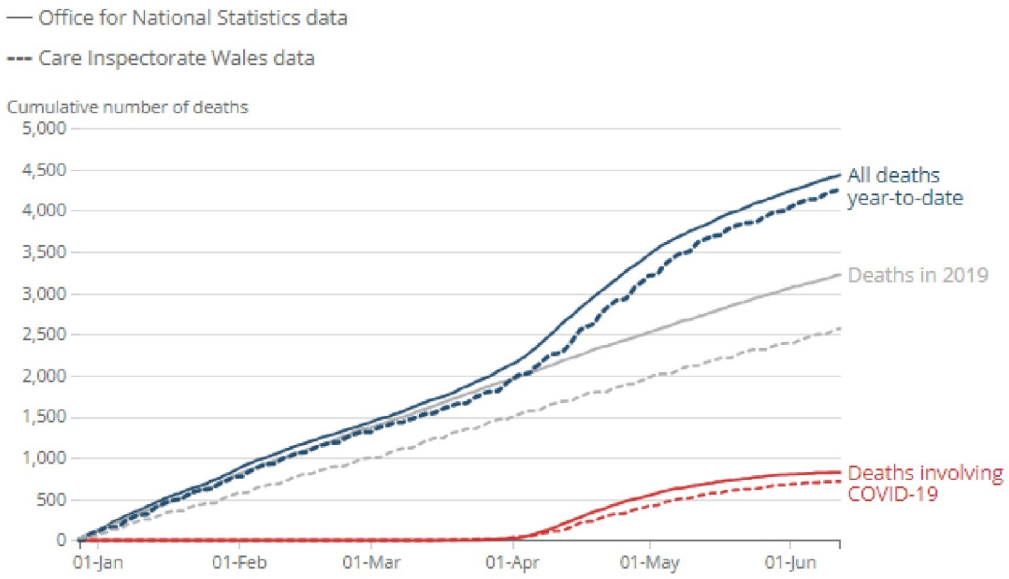
111. The Office for National Statistics determined place of death using information recorded on the death certificate regarding place of death and usual residence. Whilst I do not have a detailed working knowledge of the methods used by the Office for

National Statistics, I understand information on the death record is linked to a communal establishment file to determine the type of communal establishment.

112. The Care Inspectorate Wales data was based on care homes registered with the Care Inspectorate. A care home in Wales is defined in the Regulation and Inspection of Social Care (Wales) Act 2016, where a "care home service" is the provision of accommodation, together with nursing or care at a place in Wales, to persons because of their vulnerability or need.".

113. Knowledge and Analytical Services shared the Care Inspectorate data directly with the Office for National Statistics to support quality assurance of both the Care Inspectorate Wales and the Office for National Statistics data, and to support the Office for National Statistics publication of data relating to mortality in care homes. A quality assurance exercise in June 2020 identified some differences in the coverage of care homes when comparing Office for National Statistics and Care Inspectorate data. The Office for National Statistics typically used a slightly broader definition of care homes, and had some homes recorded as being registered with the Care Quality Commission (for England) but with a Welsh postcode. Additionally, there were examples where care homes had deaths notified in the Office for National Statistics data, but Care Inspectorate Wales had not been notified of a death. But generally the two sources followed similar trends, as shown in Figure 1 below (taken from an Office for National Statistics publication from 3 July 2020, exhibited at **SH/35-INQ000513655**).

Figure 1: Cumulative number of deaths of care home residents from 28 December 2019 to 12 June 2020, register up to June 2020, Wales



Source: Office for National Statistics and the Care Inspectorate Wales

114. Table 1 below is also taken from an Office for National Statistics publication from 3 July 2020. It summarises the similarities and differences in definitions used by the Office for National Statistics, Care Inspectorate Wales and Care Quality Commission in relation to Covid-19 deaths in care homes.

Table 1: Definitions of Covid-19 deaths in care homes between different sources

	ONS COVID-19 deaths registered	ONS COVID-19 death occurrence (actual date of death)	Care Quality Commission deaths in care homes (date of notification received)	Care Inspectorate Wales deaths in care homes (date of notification received)
Coverage	Registrations in England and Wales	Registrations in England and Wales	Death notifications sent by registered care home operators in England to CQC	Death notifications sent by registered care home operators in Wales to CIW
	Selected UK figures are included in the weekly release	In discussions with devolved nations to create UK estimates in the near future		
Inclusion	Any place of death, including care homes	Any place of death, including care homes	Deaths in care homes – deaths of care home residents that occurred elsewhere are also collected	Deaths in care homes – deaths of care home residents that occurred elsewhere are also collected
	Deaths where COVID-19 has been mentioned on the death certificate	Deaths where COVID-19 has been mentioned on the death certificate	Deaths where the care home provider has stated COVID-19 as a suspected or confirmed cause of death on the death notification	Deaths where the care home provider has stated COVID-19 as a suspected or confirmed cause of death on the death notification
Timeliness	Weekly registrations are 11 days behind because of the time taken to register, process and publish	Weekly registrations are 11 days behind because of the time taken to register, process and publish	Daily deaths notifications by date of notification - these take on average 4 days to receive and process	Daily deaths notifications by date of notification
			Data are published weekly by ONS Deaths which were notified to CQC from 10 April 2020	Data are published weekly by Welsh Government

115. The above table focuses largely on data for England and Wales. Mortality data for other parts of the UK is produced by National Records of Scotland and the Northern Ireland Statistics and Research Agency. This introduced some further differences in definitions and coverage. The Four Nations Adult Social Care Group, referred to earlier in this statement, collaborated with the Office for National Statistics to assess the feasibility of producing a UK-wide estimate of deaths in care homes, following a request from the Inter-Administration Committee. The group concluded that it was not possible to produce a consistent estimate across the UK because of the different definitions of a care home used across the UK. These differences are set out in Table 2 below, which came from the Four-Nations Adult Social Care Group.

Table 2: Definitional differences in care homes, and differences in the types of care and care needs that are provided for in England, Wales, Scotland, and Northern Ireland

	England	Wales	Scotland	Northern Ireland
Care Types				
Care home with nursing	Yes	Yes	Yes	Yes
Care home without nursing	Yes	Yes	Yes	Yes
Convalescent home	Yes	No	No	No
Respite care	Yes	Yes	No	No
Mental health crises house	No	No	No	Yes
Rest home	Yes	No	No	No
Joint user hospital	No	No	Yes	No
Contractual hospital	No	No	Yes	No
Hospice	No	No	Yes	No
Care needs				
Elderly care	Yes	Yes	Yes	Yes
Learning disability	Yes	Yes	Yes	Yes
Dementia care	Yes	Yes	Yes	Yes
Terminally ill	Yes	No	Yes	Yes
Treatment of disease, disorder, or injury	Yes	No	No	Yes
Therapeutic communities (drug/alcohol dependence)	No	No	No	Yes
Blood borne viruses	No	No	Yes	No

Covid-19 Infection and Mortality Analysis

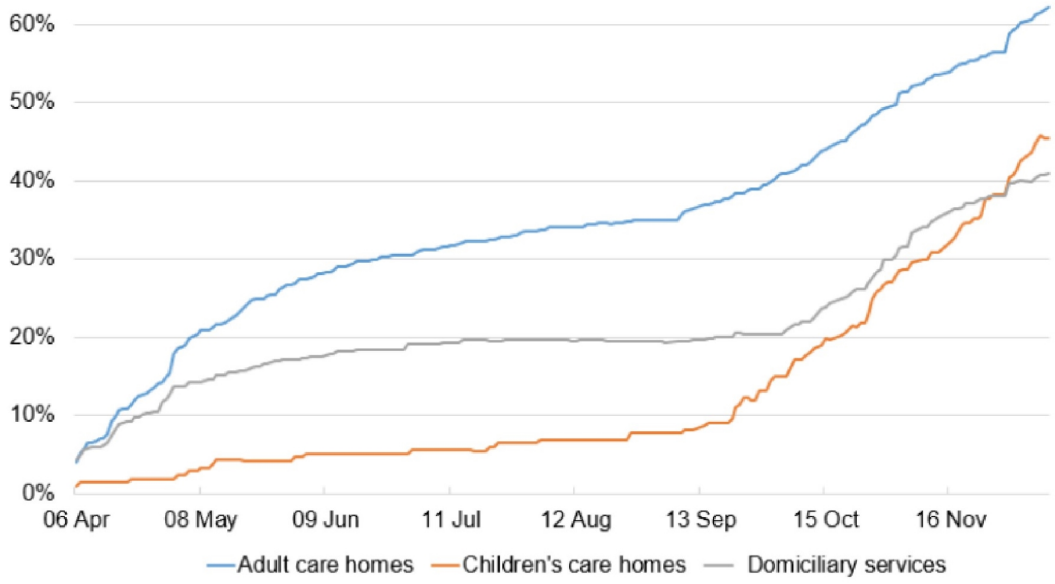
Domiciliary Care Services

116. During the Covid-19 pandemic, data on infection and mortality among domiciliary care services was very limited. In 2020, Knowledge and Analytical Services used data from Care Inspectorate Wales on the number of domiciliary care services

that had reported at least one confirmed case of Covid-19 in staff or service users. This data is not available separately for staff and service users and it cannot be broken down into characteristics such as age, sex or ethnicity.

117. Figure 2 is taken from the Covid-19 data monitor on the last time this data was included. It shows that, up to 11 December 2020, 41% of domiciliary care services had reported at least one confirmed case of Covid-19 to Care Inspectorate Wales.

Figure 2: Percentage of care services reporting at least one confirmed case of Covid-19 to Care Inspectorate Wales, 6 April to 11 December 2020.



Source: Care Inspectorate Wales

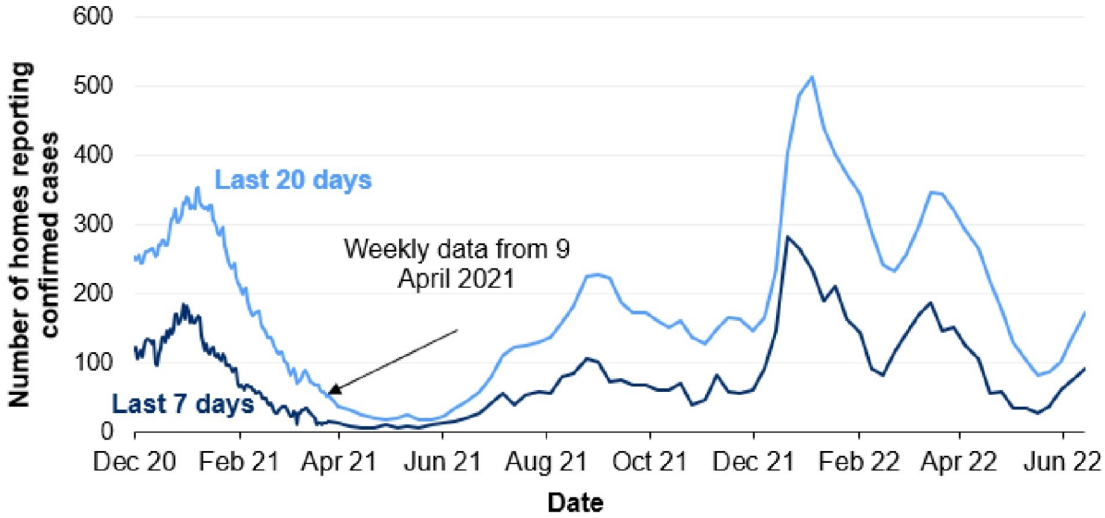
Care Homes: Infections

118. Until mid-December 2020, data was available from Care Inspectorate Wales on the cumulative number of care homes that had notified the inspectorate of at least one case of Covid-19 in staff or residents. Figure 2 above includes this data. As at 11 December 2020, 667 care homes had reported a case of Covid-19, equivalent to 62% of all adult care homes.

119. From 16 December 2020, the presentation of the data changed to show the number of adult care homes which had notified the Inspectorate of one or more confirmed cases of Covid-19 over the previous 7 or 20 days. Following Welsh Government guidance issued on 17 December 2020, Covid-19 outbreaks could be declared as over once 20 days had elapsed since the last affected individual returned a positive test or manifested symptoms. The data is shown in Figure 3 below. This covers both staff and residents. Although data was available from Care Inspectorate Wales which separately identified staff and residents, this was not used by Knowledge and Analytical Services. This was based on advice from Care Inspectorate Wales about the quality of the data when separating out staff and service users

120. The largest numbers of care homes reporting cases were seen in January 2022, with smaller peaks in January 2021, September 2021 and March/April 2022.

Figure 3: Number of adult care homes which have notified Care Inspectorate Wales of one or more confirmed cases of Covid-19 in the past 7 or 20 days, up to 30 June 2022.



Source: Notifications of Cases received by Care Inspectorate Wales

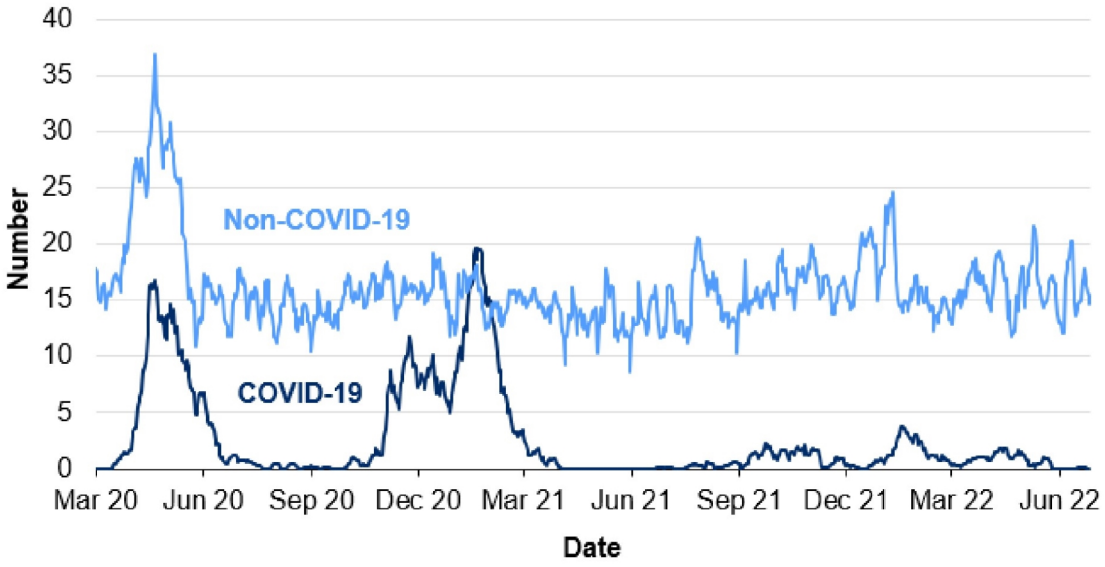
Care Homes: Mortality

121. Figure 4 shows data from Care Inspectorate Wales on the number of notifications of deaths of residents in adult care homes, broken down by Covid-19 and non-Covid-19 causes. Data covers the period 1 March 2020 to 29 June 2022. Due to working patterns, there tends to be a lower number of notifications of confirmed Covid-

19 deaths during the weekends when compared to notifications for Monday to Friday. There is often a larger number of notifications on a Monday because of a lag in providing notifications over the weekend. For this reason, the data is presented as a 7 day rolling average. The location of death may be in the care home, in hospital or another location. The data is based on reports by care home providers and not necessarily laboratory confirmed tests.

122. The data shows three distinct peaks in Covid-19 death notifications. The first of these coincides with the first wave of the pandemic, peaking in mid-April 2020. There were also a large number of death notifications categorised as non-Covid-19 deaths at this point. There are subsequent peaks in Covid-19 death notifications in December 2020 and January 2021.

Figure 4: Deaths notified to Care Inspectorate Wales of care home residents by cause of death and day of notification (7 day rolling average), 1 March 2020 to 29 June 2022



Source: Notifications of Service User Deaths received by Care Inspectorate Wales

123. Table 3 shows the number of notifications of deaths of residents of adult care homes by waves, with the waves as defined in the inquiry's M6/SH/01 Rule 9 request[1].

Table 3. Notifications of deaths of residents from adult care homes by date of notification and cause

[1] Waves defined in the Rule 9 request as Wave 1: 01.03.2020 to 31.05.2020; Wave 2: 01.09.2020 to 20.04.2021; and Wave 3: 1 May 2021 - February 2022.

	Non COVID-19 related deaths	Total Covid-19 deaths	Total deaths
Wave 1: 01.03.2020 to 31.05.2020	2,008	650	2,658
Wave 2: 01.09.2020 to 20.04.2021	3,511	1,166	4,677
Wave 3: 01.05.2021 to 28.02.2022	4,701	234	4,935

Source: Care Inspectorate Wales

Adult Social Care Settings and Demand

124. In March 2020, at the outset of the pandemic, Care Inspectorate Wales reported that there were 1,053 adult care home services in Wales, with 25,493 registered places. There were also 18 additional services recorded as "adult and children's care homes", with 145 places. Using annual data published by the Care Inspectorate, by March 2022, the number of adult care homes had fallen slightly to 1,033 settings with 25,332 places.

125. The care home capacity tool is a self-service platform established by Data Cymru in early 2022. (Data Cymru is a Welsh local government company which offers a range of specialist support designed to help its clients find and use data). The platform is built using the Care Inspectorate registration data, which means there is a record for all registered care home beds in Wales. Care homes are encouraged to create a profile in the platform which allows them to indicate if their beds are currently occupied or vacant. It is not a requirement that care homes create a profile, and so the capacity tool does not have 100% coverage of registered care homes (as of 2024, approximately 85% of care homes had registered). Therefore, it is a useful indication of care home capacity and occupancy levels but does not give precise detail on where all vacant beds exist in Wales. Knowledge and Analytical Services was aware of developments with the capacity tool but did not use data from it during the pandemic period. However, it may have been used by other parts of the Welsh Government.

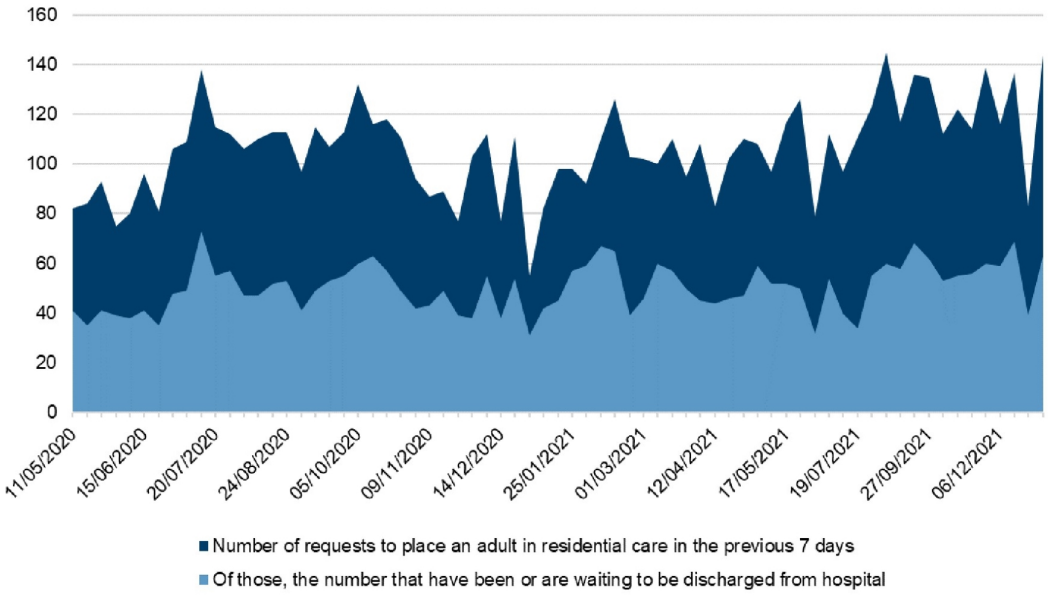
126. Knowledge and Analytical Services did not have access to and did not use Care Inspectorate check-in call data (a system set up by the Inspectorate to record challenges from care home providers around the challenges they were facing).

Demand for Residential Care

127. The Checkpoint return asked local authorities to state the number of requests they had received in the last seven days to place an adult in residential care; and of these the number that had been or were waiting to be discharged from hospital. This question changed in January 2022 to focus on those needing long term care home accommodation. Figure 5 below shows the data collected from May 2020 to January 2022.

128. While there was fluctuation throughout 2020 and 2021, the overall demand for residential care remained relatively stable for much of this period at between 100 and 140 requests per week. There was a noticeable dip in January 2021, as would be expected for the Christmas period. The number of requests were also relatively low initially during May 2020.

Figure 5: Local authority social services requests for residential care, 11 May 2020 to 17 January 2022



Source: Social Care Checkpoint

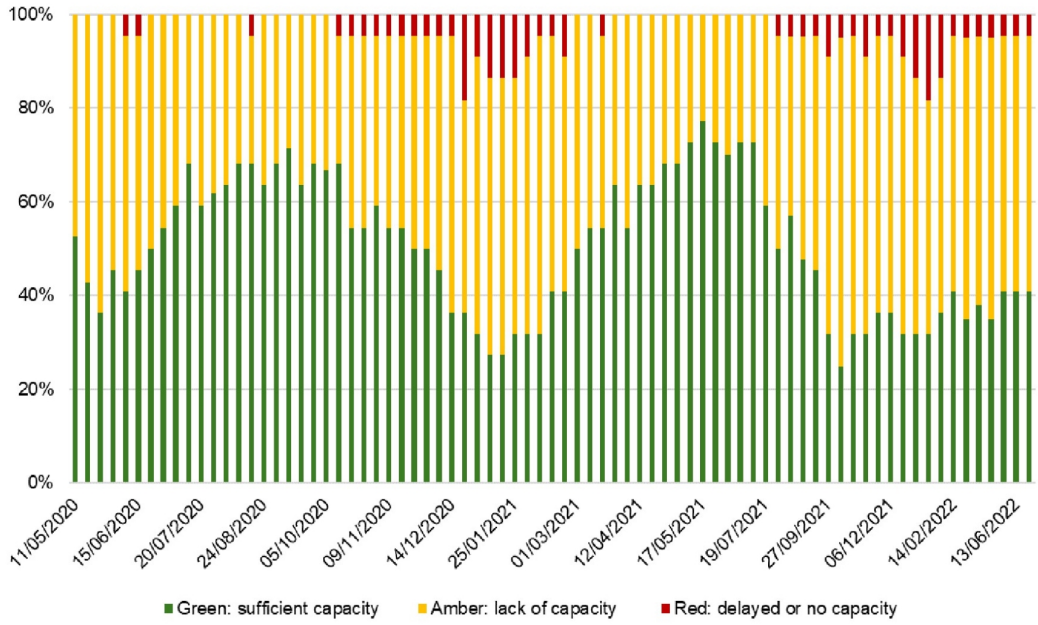
Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

129. The Checkpoint return asked local authorities to rate their capability to place adults with a care and support plan who require residential care in the appropriate residential setting.

a. Green: Good. We currently have sufficient capacity internally or are able to source capacity from the independent sector to meet our needs.
b. Amber: We are experiencing a lack of capacity internally and are finding it difficult to source enough capacity externally to be able to meet the needs of all adults requiring residential care.
c. Red: We are unable to find appropriate placements for adults requiring residential care leading to significant delays.

130. Figure 6 shows that initially in May 2020, fewer than half of local authorities reported they were able to find placements without any challenges. In January 2021, only a third of local authorities were able to source sufficient placements. This was also the case from the end of September 2021 to January 2022 but increased to about 40% of local authorities by July 2022. However, aside from those periods, the majority of local authorities reported they could provide placements without delay. There was a noticeable seasonal trend to the responses through 2020 and 2021, however in summer 2022 the proportion of local authorities reporting fewer challenges did not return to the level seen in summer 2021.

Figure 6: Local authority social services capability to provide residential care, 11 May 2020 to 4 July 2022



Source: Social Care Checkpoint

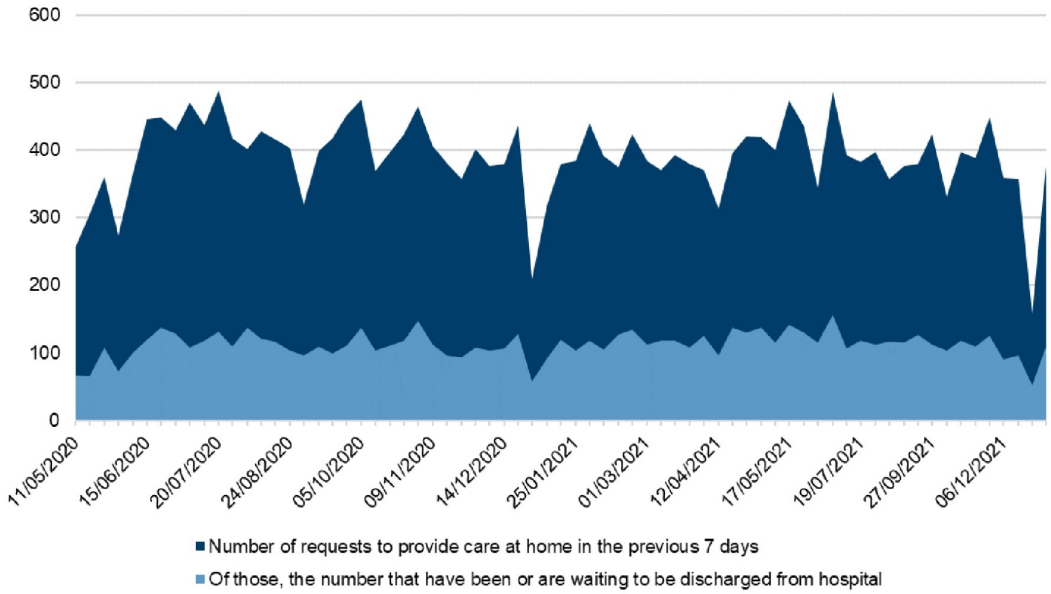
Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

Demand for Domiciliary Care

131. The Checkpoint return asked local authorities to state the number of requests they had received in the last seven days to provide care at home; and of these the number that had been or were waiting to be discharged from hospital. The question changed at the end of January 2022 to ask about those identified as needing domiciliary care, the number that were or had been waiting in hospital and the number currently waiting for domiciliary care. Figure 7 below shows the data collected from May 2020 to January 2022.

132. There was fluctuation throughout 2020 and 2021, but the overall demand for domiciliary care remained relatively constant at between 300 and 500 requests per week. The number of requests were relatively low initially during May 2020. The noticeable dips in January 2021 and January 2022 cover the Christmas period.

Figure 7: Local authority social services requests for care at home, 11 May 2020 to 17 January 2022



Source: Social Care Checkpoint

Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

133. The Checkpoint return asked local authorities to state the number of packages of domiciliary care reduced or withdrawn in the last seven days (due to Covid-19); and of these the number that had been reduced or withdrawn by different sources (i.e. the local authority, the care provider or the service user themselves). In November 2020, the question around reducing or withdrawing packages was separated into two questions, one covering reduced packages and one covering withdrawn packages. This data ceased to be collected in January 2022 as it was considered no longer to be a priority for data collection.

134. Initially, in May 2020, more than half of local authorities reported having to reduce or withdraw packages of care. Before the question changed into two separate questions in November 2020, 41% of local authorities were having to reduce or withdraw packages of care at the end of October 2020. After the question split, in November 2020, 29% reported reducing packages and 38% reported withdrawing

packages. Throughout 2021 the proportion of local authorities reporting reducing or withdrawing packages of care gradually reduced to around 20%.

Figure 8a: Local Authority Social Services reporting of reduced or withdrawn domiciliary care packages, 11 May 2020 to 26 October 2020

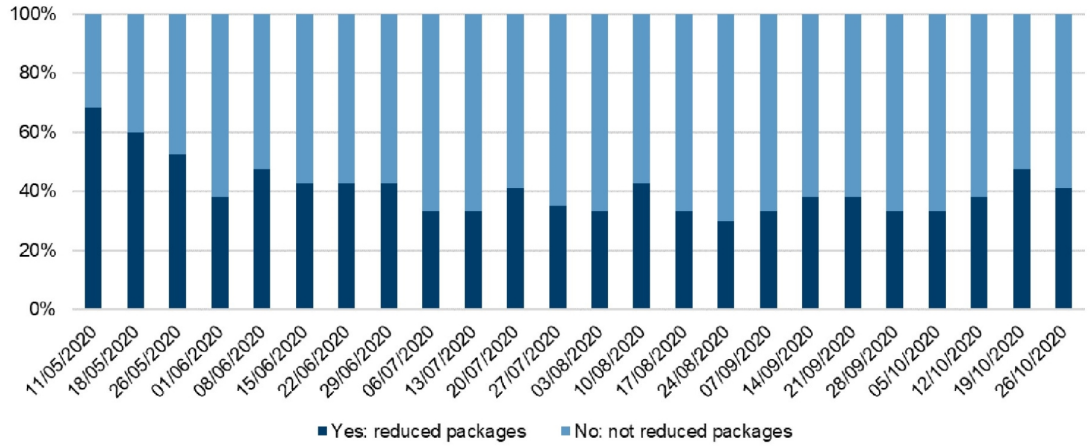


Figure 8b: Local Authority Social Services reporting of reduced domiciliary care packages, 2 November 2020 to 17 January 2022

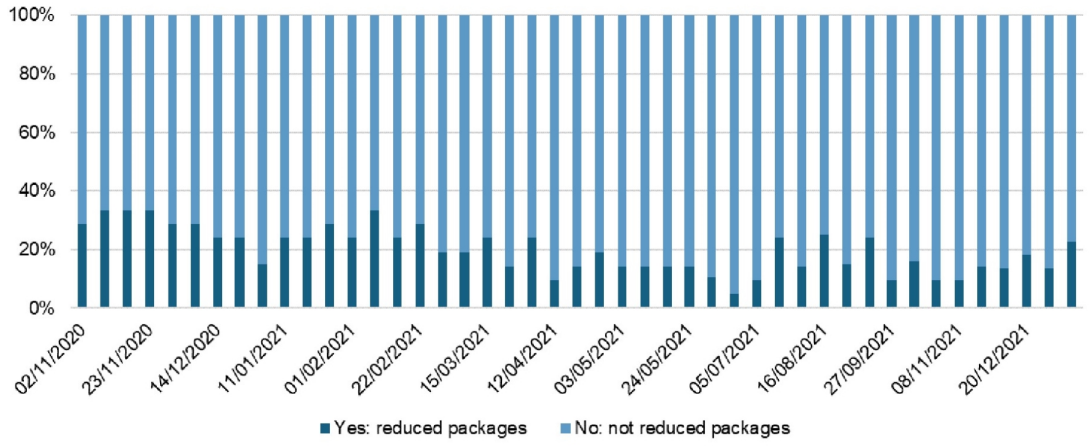
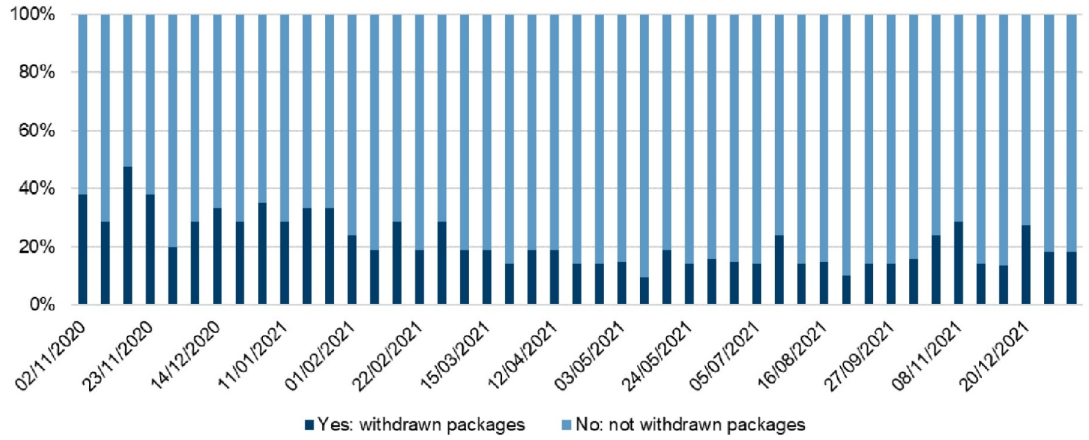


Figure 8c: Local Authority Social Services reporting of withdrawn domiciliary care packages, 2 November 2020 to 17 January 2022



Source: Social Care Checkpoint

Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

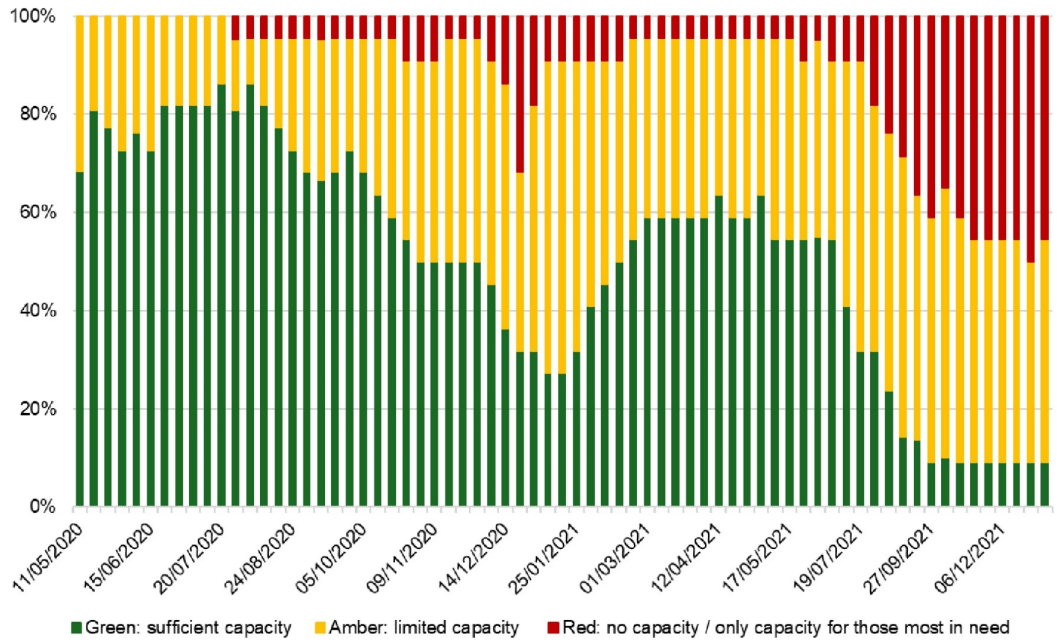
135. The Checkpoint return asked local authorities to rate their capability to provide care at home (or domiciliary care).

a. Green: Good. We currently have sufficient capacity internally or are able to source capacity from the independent sector to meet our needs.

b. Amber: We have limited capacity internally and are finding it difficult to commission enough hours from the independent sector. We can provide care at home, but there are significant delays.
c. Red: We have no internal capacity and there is no capacity we can commission in the independent sector. We are only able to provide care at home for those most in need.

136. Figure 9 shows that local authorities were initially positive about their ability to provide domiciliary care during much of 2020, with typically over 70% of local authorities stating they had no capacity issues until after summer 2020. However, from October 2020, there was a gradual decline in domiciliary care capacity through to the end of 2020 and there were significant challenges reported during January 2021. Up until summer 2021, only about half of local authorities were able to meet demand without delays. There was a further decline in domiciliary care capacity with even more significant challenges in winter 2021/22 with about 10% of local authorities reporting they were able to meet demand without delays.

Figure 9: Local authority social services capability to provide care at home (domiciliary care), 11 May 2020 to 17 January 2022



Source: Social Care Checkpoint

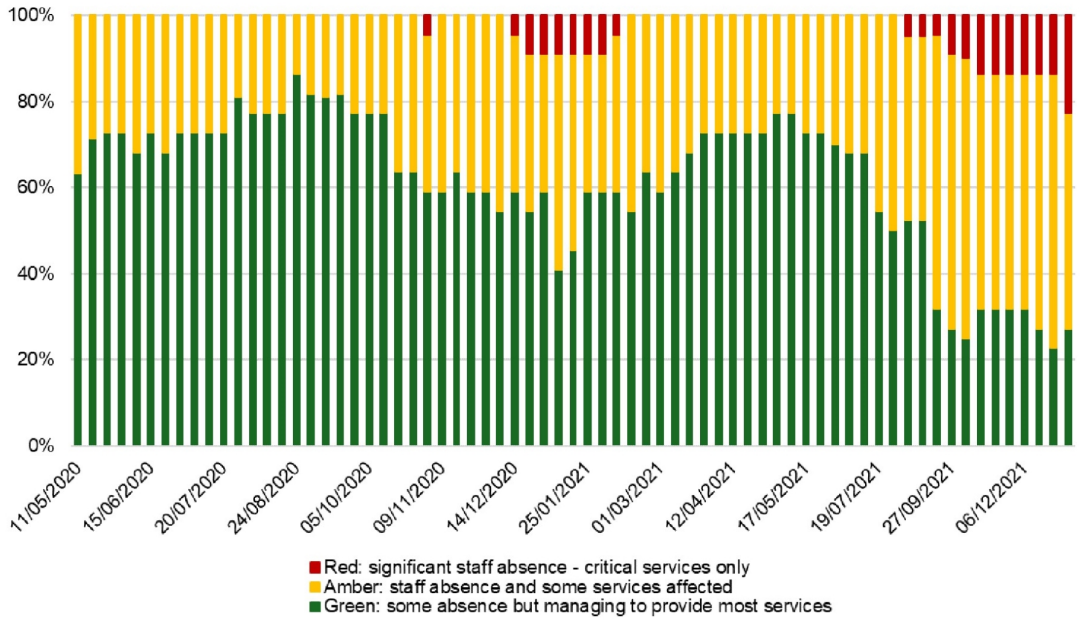
Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

137. The Checkpoint return asked local authorities to rate their ability to operate their adult services.

a. Green: We have some staff absence, but are managing to provide cover for most services.
b. Amber: We have staff absent and some services are being moderately affected, but we are still able to provide cover.
c. Red: We have significant numbers of staff absent and are only able to cover critical services.

138. From May to November 2020, typically over 70% of local authorities were reporting they were able to provide services sufficiently. However, there was a drop in January 2021 to below 50%. While services recovered in the summer of 2021, by September fewer than half of local authorities could provide most services and this continued to decline through to January 2022. Collection of this measure ceased in January 2022.

Figure 10: Local authority social services adult services ability to operate, 11 May 2020 to 17 January 2022



Source: Social Care Checkpoint

Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

Adult Social Care Workforce

Demographic Data: Social Care Wales

139. Social Care Wales is responsible for reporting on the social care workforce. It published a detailed annual report on the social care workforce as well as reports on people on registers.

140. The workforce report brought together three separate data collection processes that had previously been undertaken by Social Care Wales and the Welsh Government. The first workforce report was published in June 2022, covering the 2021 reference period. Registration reports have been available for longer. However, the elements of the social care workforce which were required to register with Social Care

Wales increased over this period. Workers in adult care homes were required to register from 1 October 2022.

141. The annual workforce report gives a snapshot of the social care workforce in Wales on 31 March each year. The data for 2021 was collected by a survey of local authorities between April and August 2021 and was published in 2022. The report includes information on gender, age, ethnicity and Welsh language ability of the workforce, with some breakdowns for local authority and commissioned provider staff. The report includes information on contract type for the overall workforce, as well as breakdowns by service area including adult residential care and domiciliary care, as well as role types within service areas. There is also information on sickness absence. No other morbidity data is available.

142. Social Care Wales received data for 72,440 people working in social care, resulting in an estimated 85,990 to 95,332 people working in social care in Wales on 31 March 2021, with about two-thirds of people employed in commissioned services and a third in local authority-run social care services. An estimated 30,531 people work in adult residential care, 20,644 work in domiciliary care and there were 10,236 personal assistants. It was estimated that 81% of the workforce is female, and a higher proportion of younger people (16 to 35 years of age) make up the workforce in commissioned services, while for local authorities those aged 46 to 65 make up the largest group of employees. Workers who were reported as White made up most of the social care workforce in Wales (89.1%). Overall, 78.5% of those employed in social care in Wales are employed on permanent contracts. Working patterns for those in local authority and commissioned services are broadly similar for full time (36hrs+), at approximately 50%. It was reported that 10,423 people started a new role in social care in Wales and 7,987 left social care during the year 2020 to 2021.

143. The annual workforce report is the most comprehensive set of statistics on the social care workforce in Wales. It is the key source for understanding, in detail, the size and shape of the social care workforce from 2021 onwards. However, the data is produced annually so it does not necessarily provide real time, timely insight. It is still a relatively new data collection process, and this can take some time to bed in. Commissioned providers are included in the data collection, but Social Care Wales report that the completion rate was lower for this sector than for local authority

providers (99.6% completion for local authorities in 2021, compared to 71.5% for commissioned providers).

144. Social Care Wales also report annually on the number of staff on the register for certain roles. The registration data reports cover social workers, social work students, adult care home managers, domiciliary care managers, residential child care managers, domiciliary care workers and residential child care workers. The reports vary by role, but typically include information on total numbers registered, employment sector, qualifications and some information on protected characteristics. Social Care Wales state that it uses the registers data to inform and quality assure the annual workforce report.

Demographic Data: Social Care Checkpoint

145. The Checkpoint was established during the pandemic to provide timely insights on local authority social services. The Checkpoint return asked for the number of directly employed social services staff within the local authority. This information was collected weekly from May 2020 to May 2021 and then fortnightly from June 2021 to March 2022. After this point, it became a monthly collection. A copy of the data collection form from 11 May 2020 is exhibited at **SH/21-INQ000513652.**

146. The main purpose of the Checkpoint was to gather near real time insights on the impact of the pandemic on local authority social services. The Checkpoint return was not intended to be a lengthy or detailed statistical collection, so it did not ask for any demographic information other than the total number of staff. This was requested as full-time equivalents in the first week then as headcount thereafter. Headcount data was understood to be simpler for local authorities to provide and was more consistent with other data items collected in the Checkpoint. The Checkpoint return asked for workforce capacity, including any additional staff supporting the local authority. This was collected weekly from May 2020 to December 2021. Workforce data was collected for all social services combined – adults and children's services cannot be separately identified.

Demographic Data: Other Statistical Surveys

147. Up to March 2019, information on local authority social services staff was collected by the Welsh Government. This included numbers of staff by local authority and role type. This collection went on to become part of the Social Care Wales survey that is used to create the annual workforce report, a plan that pre-dated the pandemic.

148. There are a number of other surveys and data collections which collect information on occupation or industry of employment. They do not focus specifically on social care but can be used to provide workforce estimates for the sector in Wales. Regular Office for National Statistics statistical surveys like the Labour Force Survey and Annual Population Survey can be used to provide estimates of specific industry or occupational groupings, some protected characteristics and information like zero hours contracts. Standard Industrial Classification codes and Standard Occupational Classification codes are used to define the sectors and occupations of interest. This requires some judgement on which codes to include, as sectors/occupations could be defined in multiple different ways. A limitation of these surveys is that when looking at detailed groups (e.g. zero hours contracts by sector; social care workers from a minority ethnic group) the analysis can be based on a very small number of survey responses, which can result in either low quality estimates or a requirement to use high-level sector groupings. However, despite these quality challenges, the Annual Population Survey can generally provide a reasonable estimate of the size and structure of the workforce at a Wales level.

149. The Census of population can provide detailed demographic information (e.g. age, sex, ethnicity, disability, health) by industry or occupation. However, the data available throughout the pandemic was from the 2011 census. As it was a decade old, it would not have captured any recent change in the size or composition of the workforce. The Annual Population Survey would generally have been the preferred source during the pandemic, rather than the census.

Adult Social Care Workforce Status

150. Knowledge and Analytical Services did not have access to or use any information from the Care Inspectorate Wales check-in call data.

151. Local authorities were asked to provide a red/amber/green status for workforce (covering both adults and children's services).

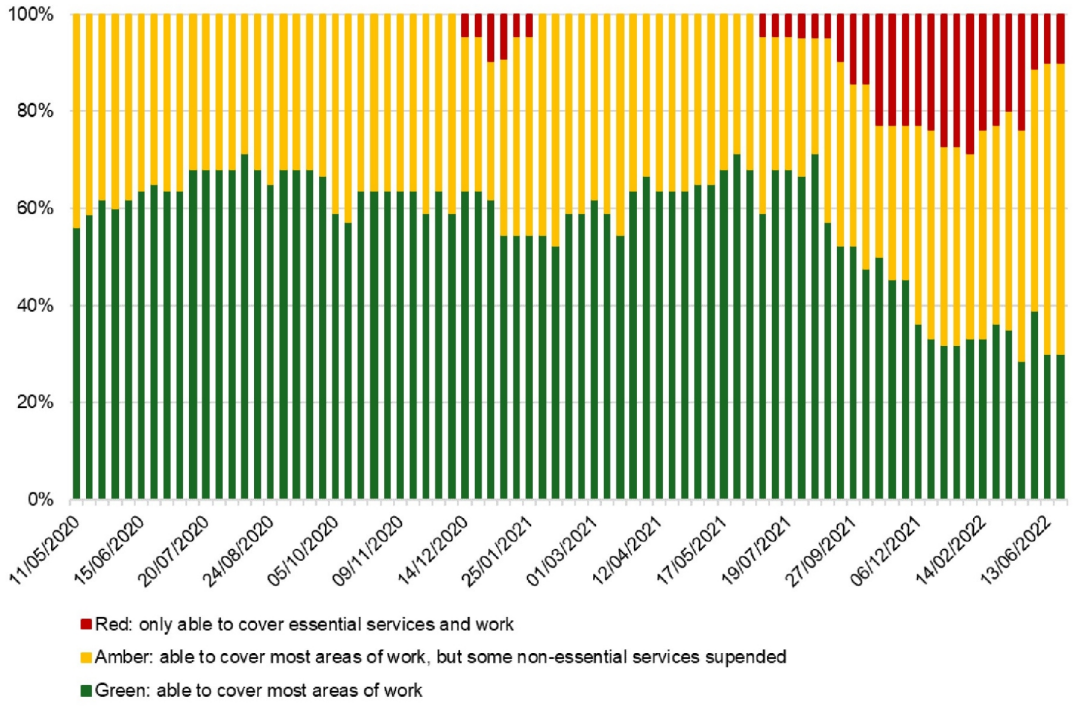
a) Green: We have sufficient staff to provide cover for all essential roles. We are able to transfer staff where appropriate and are not currently experiencing any major issues covering absence or employing additional staff.

b) Amber: We are able to cover most areas of work, but some non-essential services have had to be suspended, or operated on a priority basis. We are currently experiencing some difficulty in recruiting certain staff groups to provide the cover needed.

c) Red: We are only able to cover essential services, and work is being prioritised to those most in need. We are experiencing severe difficulties in providing cover for key areas and are not being successful in recruiting into those roles.

152. Initially, fewer than half of local authorities reported having to suspend non-essential services or severe workforce shortages, despite absence rates being above 10% of the workforce. The absence rates peaked in May 2020 and January 2021. However, local authority self-assessed capacity did not follow the same pattern. It saw a marked decrease from December 2021, with the highest levels of capacity challenges reported in early 2022. Throughout 2022 there was a gradual decline in the number of local authorities reporting a green status, with around a third reporting no capacity issues.

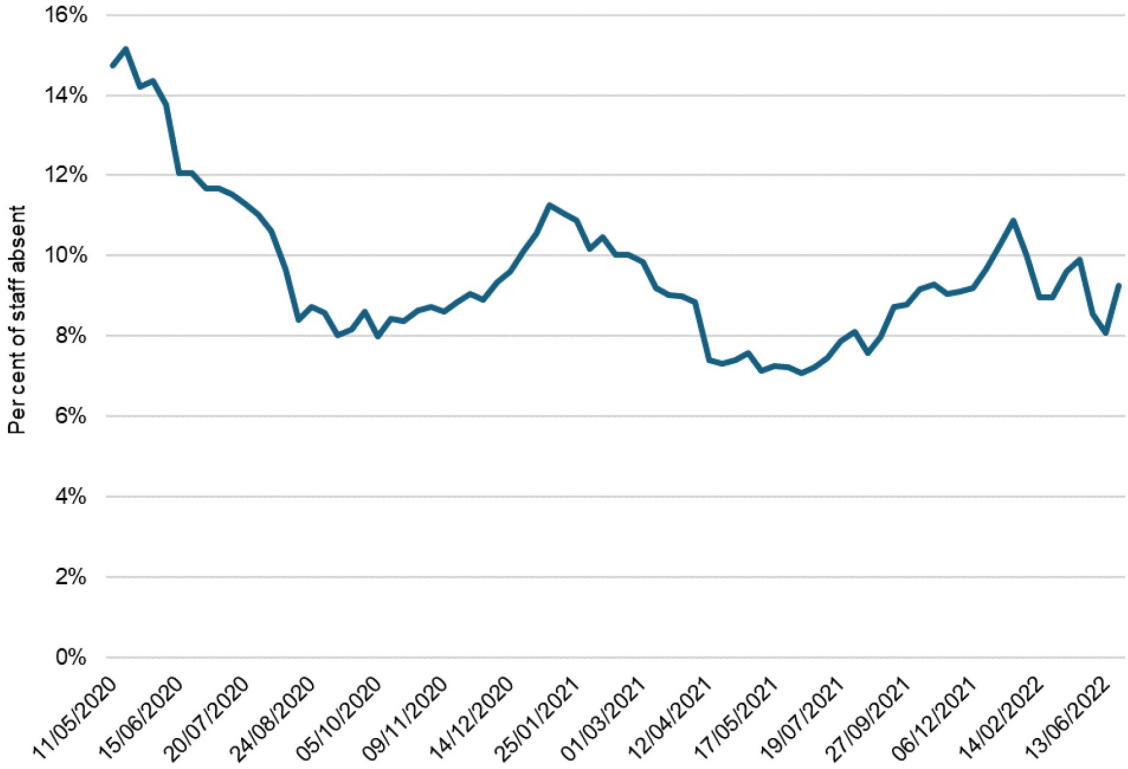
Figure 11: Local authority social services workforce status, 11 May 2020 to 4 July 2022



Source: Social Care Checkpoint

Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

Figure 12: Local authority social services staff absence (% Wales), 11 May 2020 to 4 July 2022



Source: Social Care Checkpoint

Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

Infection and Sickness Absence in Social Care Workforce

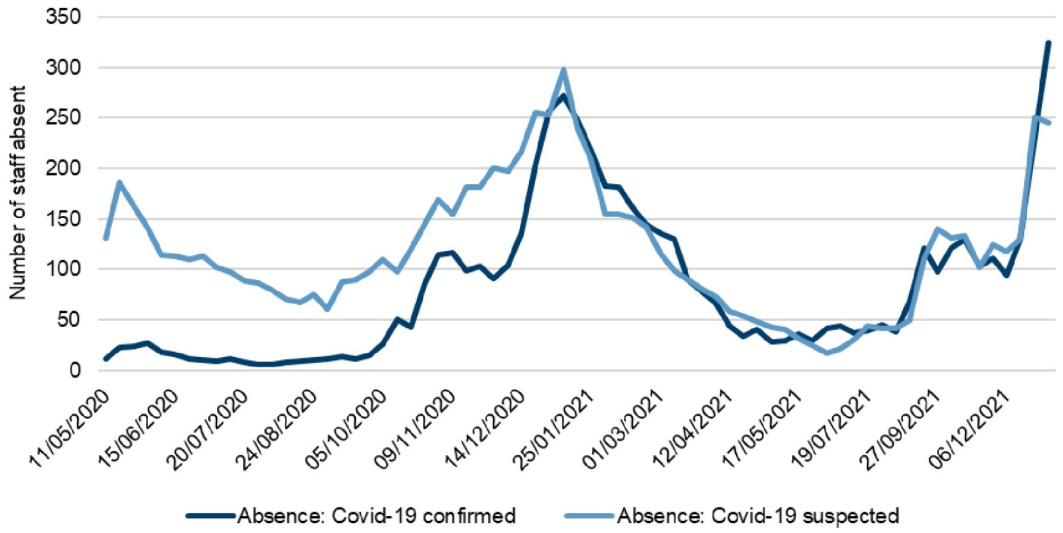
153. The Checkpoint return asked local authorities for the number of staff directly employed within social services who were absent for various reasons including Covid-19 related illness, other illness, shielding and other absence. The number of staff absent and overall absence rates were at their highest in May and early June 2020. The proportion of staff absent followed a seasonal pattern and increased during the winter.

154. The Checkpoint return also asked local authorities for the number of staff directly employed within social services (adults and children's services) who had been tested for Covid-19 and, of these, how many had tested positive, negative or were awaiting results. As of 26 May 2020, 904 tests were undertaken for local authority staff,

of which 9% were positive for Covid-19. On 7 December 2020, 1,269 tests were taken, of which 14% were positive. However, it was noted at the time that since the data is held by the local health boards, the local authorities may not be aware of all tests undertaken. Due to the local authorities not being able to reliably provide data on Covid-19 testing, the data stopped being collected on Covid-19 tests in the Social Care Checkpoint after 7 December 2020.

155. The Social Care Checkpoint asked also local authorities to indicate where the absence of their staff was due to Covid-19 infections (either suspected or confirmed). The highest rates of suspected or confirmed Covid-19 were reported in January 2021 and January 2022. This corresponds to the peaks in total absences seen in those periods.

Figure 13: Local authority social services - Covid-19 Staff Absence (Wales), 11 May 2020 to 17 January 2022



Source: Social Care Checkpoint

Note: Responses may not have been received from all 22 local authorities for every Social Care Checkpoint collection. Numbers in the chart are based on local authorities that responded only. Some changes may therefore reflect differences in coverage.

156. In terms of other sources on Covid-19 infection in the social care workforce, the Office for National Statistics produced some analysis from the Covid-19 Infection Survey on people testing positive by occupation, which included caring occupations, but as far as I can recall this analysis did not provide figures for Wales.

157. Notifications data from Care Inspectorate Wales on Covid-19 cases covered both care home staff and residents. Although data was available from Care Inspectorate Wales which separately identified staff and residents, this was not used by Knowledge and Analytical Services. This was based on advice from Care Inspectorate Wales about the quality of the data when separating out staff and service users.

158. Covid-19 testing data published by the Welsh Government included some breakdowns on the number of positive and negative tests for care home staff and residents, however there were often issues with identifying these groups in a consistent way within the testing data. Furthermore, this data was not used to understand Covid-19 prevalence and was instead a measure of testing activity which was used to inform testing policy and operations.

Mortality of the Social Care Workforce

159. The Office for National Statistics produced official statistics on mortality for Wales and England, using information on death certificates. Office for National Statistics also produced regular analysis on mortality by occupation for workers aged 20-64 years old. This included information on the deaths of social care workers, combined across all types of social care, not just adult social care. The annex of analysis exhibited later in this statement sets out the date and scope of each internal briefing that was provided by Knowledge and Analytical Services on mortality related to the care sector.

160. Early in the pandemic the Office for National Statistics' published analysis combined figures for England and Wales into a single total, because the figures were too small to publish separate Wales data. However, in order to monitor the impact of the pandemic in Wales, the Welsh Government requested and was provided with separate Wales figures for internal use only. As the pandemic progressed, the Office for National Statistics began to publish separate Wales figures. The first separate figures for the number of deaths involving Covid-19 in health care and social care workers resident in Wales was published by the Office for National Statistics on 26 June 2020.

161. Office for National Statistics analysis shows that between 9 March 2020 and 31 March 2022, there were 65 deaths involving Covid-19 of social care workers in Wales aged 20-64. I exhibit the analysis at **SH/36-INQ000513654**. Note that these are not figures for deaths in service in Wales, but figures for Welsh residents based on the occupation recorded on their death certificate. The Office for National Statistics found that, for England and Wales combined, men and women who worked in social care occupations had higher rates of death involving Covid-19 when compared with rates of death involving Covid-19 in the population among those of the same age and sex.

162. Notifications data from Care Inspectorate Wales did not provide information on deaths of care workers, instead it focused on residents of care homes.

Recipients of Care

Learning Disabilities

163. Under the Social Services and Well-being (Wales) Act 2014, local authorities are required to establish and maintain a register of children who are within the local authority's area and who are disabled, have a physical or mental impairment which gives rise, or may in the future give rise to, needs for care and support. Local authorities may also maintain a register of adults within their area to whom these same criteria apply. Whilst it is a legal requirement for local authorities to maintain these registers, it is not compulsory for someone to register themselves with a local authority. This means that the number of people on the registers is likely to be an undercount. Furthermore, local authorities do not maintain their registers in a consistent way, which makes it difficult to determine the reliability of the data recorded.

164. Data collected from local authorities provided information on the number of people on local authority registers with learning disabilities, by place of residence and age. Data was published annually, with the exception of 31 March 2020 due to the suspension of some data collections during the pandemic response. Data as at 31 March 2021 was published in February 2022 and data at 31 March 2022 was published in February 2023. The collection was discontinued after publication of 31 March 2022 data, with a view to being collected in future through the planned census on adults receiving care and support.

165. As at 31 March 2022, there were 12,303 people in Wales recorded on learning disability registers. 84% were living in community placements (for example, living with parents and family), and 16% were living in residential establishments such as care homes. Given the quality limitations mentioned above, these figures cannot be thought of as the definitive number of people with learning disabilities in Wales.

Table 4: People with learning disabilities, by age group

	2018-19	2019-20	2020-21	2021-22
Aged under 16	2,342	..	2,210	2,196
Aged 16-64	10,013	..	10,235	9,003
Aged 65+	1,152	..	1,231	1,104
Total	13,507	..	13,676	12,303

Source: Local authority registers of people with learning disabilities

Note: Data was not collected in 2019-20

166. Public Health Wales Improvement Cymru carried out analysis of Covid-19 related deaths in Wales amongst people with learning disabilities, covering the period 1 March to 26 May 2020, exhibited at **SH/37-INQ000513653**. This analysis found that, of the 15,000 individuals identified with a learning disability, at least 31 had died from Covid-19 between 1 March and 26 May 2020. The report states that "Comparison with deaths amongst all Welsh residents, suggests that the age-standardised rate of deaths involving COVID-19 is around 3x to 8x higher in this cohort than the population as a whole. Despite this, the proportion of deaths in this cohort involving COVID-19 remains similar to that in the population as a whole. This is because this cohort has a persistently higher mortality rate from causes other than COVID-19".

167. The report author notes issues with identifying people with learning disabilities who have died. He notes the approach used in the analysis (i.e. identifying a cohort of people with learning disabilities via inpatient admissions records) is likely to be biased towards individuals with relatively severe learning disabilities and relatively poor physical health.

168. Officials in Knowledge and Analytical Services received a number of iterations of the report. I exhibit:

i) a draft dated 7 May 2020, which was shared with two deputy Ministers and a number of officials on 15 May 2020 **SH/38-INQ000539021].**

ii) a version dated 25 June 2020. I exhibit at **SH/39-INQ000385286** the briefing note from 6 July 2020 that was produced for Ministers and officials on this version of the report.

iii) The final version available from the Public Health Wales website, dated 4 September 2020, **SH/37**-INQ000513653. **[].**

Demographics of Care Recipients

169. Knowledge and Analytical Services did not hold information on the personal characteristics of adults receiving care and support during the pandemic. However, plans were in place during the pandemic period to develop a new data collection that would address this gap. A new individual record level collection, the Adults Receiving Care and Support Census, was put in place for 2023-24 to collect information on the characteristics of adults with a care and support plan, the type of care and support they received, and whether they were a carer or had a carer.

170. Knowledge and Analytical Services did not have access to a timely figure on the size of the care home population or the demographics of care home residents. Prior to and during the pandemic, Care Inspectorate Wales published annual data on the number of registered places in care settings, but not the number of places that were being used. There have since been improvements in this field in relation to demographics. From 31 March 2023, Care Inspectorate Wales now reports annually on the number of people in care homes including information on age, sex and ethnicity.

Data Gaps and Limitations

171. There is a longstanding lack of parity in terms of the coverage, timeliness and granularity of data on adult social care when compared to a topic such as health. In particular, there has been a sizeable gap in data related to users of social care. Prior to and during the course of the pandemic, there was a reliance on collecting aggregated data from local authorities which summarised the volume of social care activity, for example, the total number of assessments completed, or the number of packages of care. This did not provide sufficient data or insight on the size of the population of social care service users or information about their demographics or personal characteristics, such as their age, sex or ethnicity.

172. There have been a number of developments since which seek to fill this gap. Firstly, Care Inspectorate Wales now carries out an annual data collection for registered services which provides aggregate information on the occupancy of care homes and the age, sex and ethnicity of care home residents. Additionally, Knowledge and Analytical Services recently launched the Adults Receiving Care and Support Census. This marks a move away from aggregate local authority data collections and towards individual record-level collections for adults with a care and support plan, mirroring changes to children's social care collections. The first data collection, covering the 2023-24 period, includes data items on age, sex, ethnicity, disability and language of care recipients, as well as information on the care and support received and whether someone is or has a carer. The intention is to deposit data from this collection in the SAIL Databank in future in order to facilitate linking with other datasets which will unlock further insights.

173. Despite the development by Care Inspectorate Wales to publish annual data on care home occupancy, there remains a gap in regular timely data on the size of the care home population. The care home capacity tool has filled this gap to some degree, but, as use of the tool is not mandated, it does not provide a complete picture of care home occupancy.

174. Knowledge and Analytical Services collects information from local authority social services but does not collect data from private or third sectors organisations. The Adults Receiving Care and Support Census will provide information on people with a care and support plan through a local authority, but there remains a knowledge gap on people who self-fund their own care. In the near future, we expect to be able to estimate the size of this group using data from the Adults Receiving Care and Support Census and the Care Inspectorate Wales annual return, but there will remain a gap in understanding the personal characteristics of this specific group (although the Care Inspectorate Wales annual data return provides information on the characteristics of care home residents in total).

175. Information is collected by Knowledge and Analytical Services from when adults contact social services. Little is known about preventative services that might take place prior to someone needing more intense local authority care and support, or what support they might be receiving in the wider community. In addition, existing data focuses on the volume of activity in relation to statutory duties placed upon local

authority social services departments. Little is known about people's experiences and outcomes.

176. There were gaps in the availability of data related to Covid-19 infection and mortality in care homes. The Office for National Statistics Covid-19 Infection Survey did not collect information on the care home population (or other communal establishments), and Public Health Wales's rapid surveillance data did not include prevalence estimates for care home residents (although tests from care home residents, and staff, were included in the overall case figures). This meant there was a reliance on sources like Care Inspectorate Wales notifications which provided timely insight on trends in care homes but were not designed to be a surveillance measure.

177. In terms of mortality, the Office for National Statistics mortality statistics provided the most comprehensive picture on deaths of care home residents. The rapid mortality surveillance data from Public Health Wales was not designed to capture all deaths and so excluded most deaths that occurred in care homes as well as some other settings. But this meant there was a gap in understanding Covid-19 mortality trends from care homes in a timely way, given that the official statistics from the Office for National Statistics came with a lag of 11 days. The Care Inspectorate Wales notifications data filled this gap to some extent, but Knowledge and Analytical Services did not begin routinely using this data until the start of May 2020.

178. On workforce, there were a range of sources available that described the size and make-up of the social care workforce. The main challenges were in relation to the quality and detail of the data, as estimates derived from surveys came with a high degree of uncertainty when looking at small groups (e.g specific occupations, small ethnic groups). The annual workforce report by Social Care Wales fills a considerable gap and now provides a comprehensive set of statistics on the social care workforce, but this was not available until June 2022.

179. There was no routine and systematic surveillance of Covid-19 prevalence among the adult social care workforce. The Checkpoint return attempted to monitor staff absence levels affecting local authority social services, but there was no routine data on infection or absence for care home staff. Mortality data from the Office for National Statistics provided data on the number of Covid-19 related deaths according to the occupation recorded on a death certificate, but there is no data available on in-service deaths of social care workers.

180. Data related to domiciliary care was particularly limited. As set out earlier in this statement, Knowledge and Analytical Services had access to Care Inspectorate Wales data on cases recorded by domiciliary care services, but this proved to be of limited value after more than a few months into the pandemic. The Checkpoint return collected data on domiciliary care activities, but very little was known about domiciliary care staff or service users.

Lessons Learned and Actions Taken

181. Knowledge and Analytical Services has undertaken or contributed to a number of lessons learned exercises over the course of the pandemic. The following exhibits only extend insofar as the scope of this module.

Welsh Government internal lessons learned exercises

182. Knowledge and Analytical Services contributed to a Health and Social Services Group lessons learned exercise in August 2020. This lessons learned exercise was conducted when Knowledge and Analytical Services was still part of the Health and Social Services Group. I exhibit that at **SH/40–INQ000271847**.

183. Positive areas identified included the early involvement of Knowledge and Analytical Services in the Welsh Government response; the vast range of new statistics and analysis that were produced and transparently published; the commitment of Knowledge and Analytical Services staff in contributing to the Covid-19 response; and the good working relationships developed internally (e.g. with Care Inspectorate Wales, communications teams, special advisers) and externally (e.g. with the UK Cabinet Office and the Office for National Statistics).

184. In terms of what worked less well, the exercise identified some areas of duplication or a lack of clarity on roles and responsibilities, for example between Knowledge and Analytical Services, the Technical Advisory Cell and the NHS performance and public health teams. The review also drew attention to the under-reporting of rapid mortality data in Public Health Wales (referred to in paragraph 30 of this statement), which Knowledge and Analytical Services could have advised on. The

number of dashboards being produced for different purposes was highlighted and that this could lead to confusion amongst the media and public on some of the key statistics. It was also acknowledged that the tools within the Welsh Government did not allow Knowledge and Analytical Services to easily deploy interactive digital dashboards (which ultimately led to the Technical Advisory Cell contracting this work out). Action was taken to address each of these areas.

185. Knowledge and Analytical Services recommended there should be stronger Government Statistical Service leadership in Public Health Wales on matters such as quality assurance, dissemination of data and transparency of methods (a recommendation which was later accepted by Public Health Wales). The exercise also recommended bringing together key organisations on health and care data in an information management group, and that there should be earlier planning and consideration of potential analytical questions that might be asked in a pandemic (with the work on care home discharges cited as an example that could have been anticipated sooner). The review also made some practical recommendations around having appropriate analytical surge capacity.

186. A short follow-on exercise was conducted by Statistical Services focusing on matters outside of the scope of the above exercise. This was carried out in September 2020. I exhibit that at **SH/41–INQ000271846.** It highlighted similar key messages to the previous exercise in terms of the benefits of the early involvement of Knowledge and Analytical Services in the response, and that new data and statistics were acquired, analysed and published at pace in order to inform decision making. Involvement in forums such as the Covid-19 Preparedness Bird Table and ExCovid was also recognised as a helpful mechanism for having early sight on emerging analytical requirements. Areas that were recommended for improvement were on the need for more timely local data on infection levels; a better understanding of the relationship management arrangements with Public Health Wales; plus recommendations on operational matters such as resourcing, recruitment and line management arrangements.

187. A review of the Statistical Services contribution to the Covid-19 response from June 2022 reiterated similar messages to previous reviews in terms of the benefits of setting up new, timely data collections. Although not mentioned by name in the exercise, a number of social care examples exemplified this. The willingness to embrace new data sources such as notifications data from Care Inspectorate Wales

brought new, timely understanding of the situation in care homes and made this transparently available to the public. For an area where real time data has historically been lacking, innovations like the weekly Checkpoint return brought about a step-change in the timeliness of evidence on social care to monitor and inform decision making. Many of the recommendations were not directly related to adult social care, but it included a recommendation for a central coordinating function for data and evidence during emergencies, which would enable more thorough preparation for future crises. I exhibit the review at **SH/42-INQ000271817**.

188. The Chief Statistician was also interviewed as part of the Welsh Government Civil Service lessons learned exercise coordinated by the Covid-19 Transition Board. A transcript or note from this interview was not retained (in line with the privacy notice) but relevant findings were included in the final report which is exhibited at **SH/43-INQ000090539**. The findings related to Knowledge and Analytical Services do not directly reference adult social care but they support findings from other exercises already referred to above.

External lessons learned exercises

189. The Office for Statistics Regulation published a report in October 2021 called Improving Health and Social Care Statistics: Lessons Learned from the Covid-19 Pandemic. I exhibit that at **SH/44–INQ000271834**. The review covered the statistical system across the UK and the work of Welsh Government statisticians was within the scope of this review. The Chief Statistician met with the Office for Statistics Regulation to contribute to the review. The exercise identified that the pandemic had drawn attention to existing problems and created new challenges for health and social care statistics where there were gaps in important information, with social care identified as an area with data gaps. The exercise acknowledged that building on the achievements of the pandemic and overcoming existing challenges would require strong leadership, a commitment to transparency and sufficient investment, for example in data sharing and linking, data infrastructures, and analytical resource.

190. The Office for Statistics Regulation recognised good practice by the Welsh Government including the commitment to establish an equality data unit; collaboration between the Welsh Government, NHS and academia to share data and expertise; use

of data linking for analysis; and the use of blogs and technical media briefings to communicate statistics.

Addressing lessons learned

191. A progress report by Knowledge and Analytical Services from September 2022 set out actions that had been taken at that point to address the lessons identified in the above reports. I exhibit that at **SH/45–INQ000271818**. The scope of this report is not directly related to adult social care, although the actions identified bring benefits to this and other topic areas. This includes diverse actions such as analysts now being involved in preparedness exercises; establishing links with UK Government bodies on emergencies like the National Situation Centre; and improving equality data by setting up an Equality, Race and Disability Evidence Unit.

192. The importance of data on the social care workforce, social care recipients and, in particular, care home residents, became very apparent during the pandemic. As set out in the section above on data gaps, a number of steps have already been taken to fill these gaps. This has included filling gaps on:

a) The demographics and personal characteristics of social services users, through the introduction of the Adults Receiving Care and Support Census.
b) Characteristics of care home users, through an annual data collection by Care Inspectorate Wales.
c) Care home occupancy, through the Care Inspectorate Wales annual data collection and Data Cymru's care home capacity tool.
d) The social care workforce, through detailed annual statistics produced by Social Care Wales

193. The pandemic demonstrated the importance of data to understand events, identify vulnerable groups, assess impact and monitor outcomes. But, as identified in lessons learned exercises, there was no routine planning prior to the pandemic to consider what data might be needed in an emergency or how data and analysis activities would be coordinated. This led to a need to quickly identify new data sources or stand-up new data collections from scratch. This would be improved by better embedding data and analysis into resilience planning and civil contingencies structures. To address this, I presented a paper at the Welsh Government's Strategic Evidence Board in November 2022 which set out a proposal to establish a data and evidence function as part of the National Security and Resilience division. This would

provide enhanced capacity and capability to plan and respond to the data requirements of future emergencies, as well as embedding data and evidence in the Welsh Government's emergency response structure. This approach would look to proactively and systematically understand the types of groups that might be most affected by different types of risk (e.g. care recipients) and identify the data sources that could be used in an emergency response. This team would also make connections with and learn from the experience of the UK Government's National Situation Centre. The recommendations from the Strategic Evidence Board paper were accepted and were also agreed by Risk and Preparedness Committee in October 2024. Knowledge and Analytical Services and National Security and Resilience are currently making the case for funding to establish this team. The Strategic Evidence Board paper is exhibited at **SH/46–INQ000271844.**

Further Recommendations

194. Although good use was made of existing and new data sources, there are further opportunities to improve coordination and collaboration. Data existed in a number of silos which, at times, made analysis more challenging (as demonstrated by needing to bring together data from many sources for the retrospective analysis of discharges from care homes). In future emergencies, multiple cross-departmental access to datasets should be in place to reduce the data sharing burden. Within the health and social care sphere the Digital Health and Care Wales led National Data Resource project provides an important potential mechanism to achieve this in future. The National Data Resource is a digital transformation programme which aims to make it easier to join up health and social care data from multiple sources. The National Data Resource data platform aims to enable a single digital health and care record, which should improve the ability to access, share, link and use data within health and social care in Wales.

195. Alongside this technical innovation, there is a need for the different parts of Government and the NHS to work collaboratively to identify and solve analytical questions, rather than operate in silos.

196. In preparation for future pandemics, consideration should be given to methods for timely surveillance of "at risk" populations and key workforce sectors, which would fill further data gaps. The testing infrastructure provided a considerable wealth of data

and could provide further opportunities for surveillance if other information (e.g. occupation) was collected at the same time or could be obtained by linking to another suitable source.

197. The delivery of social care through a mixture of public services and private sector organisations presents unique challenges for collecting data compared to the health sector. Whilst Knowledge and Analytical Services has taken steps to improve adult social care data collected through local authorities, the scope to improve the quality and timeliness of data on private care providers and their service users would likely require a significant investment in digital and data capability in the sector.

Supporting Documentation

198. To assist the Inquiry, I exhibit an Excel spreadsheet as **SH/47-INQ000513716**, which contains the data presented in this statement. Additionally, I exhibit as **SH/48-INQ000513717** a spreadsheet of the analysis that has been applied in relation to the scope of this module. These exhibits are presented in this form to facilitate the understanding of the key data.

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: PD

Dated: 05/02/25