Module 2b (Wales) Week Two

1. **Sir Frank Atherton (Chief Medical Officer for Wales)**
2. **Dr Rob Orford (Chief Scientific Adviser for Health for Wales)**
3. **Dame Shan Morgan (Former Permanent Secretary to the Welsh Government)**
4. **Dr Andrew Goodall (Permanent Secretary of the Welsh Government and former Director General Health and Social Services)**
5. **Dr Tracey Cooper (Chief Executive of Public Health Wales)**
6. **Dr Quentin Sandifer (Consultant Adviser for Pandemic and International Health for Public Health Wales)**
   Shavanah Taj (General Secretary, Wales Trade Union Congress)
7. **Dr Chris Llewelyn (Chief Executive of the Welsh Local Government Association)**
   Reg Kilpatrick (Director General of the Covid Recovery and Local Government Group)
8. **Jane Runeckles (Head of the Welsh Government's team of Special Advisers)**
   Toby Mason (Head of Strategic Communications for the Welsh Government)
9. **Simon Hart MP (Parliamentary Secretary to the Treasury (Chief Whip) and former Secretary of State for Wales)**

Sir Frank Atherton (Chief Medical Officer for Wales)

CMO since 2016. Long career in public health. CMO is a member of Welsh Government staff so bound by the Civil Service code of practice. I do have a degree of independence which some other civil servants perhaps don't enjoy.

Andrew Goodall was Director General of Health and Social Services. At the start of the pandemic, I reported to Dr Andrew Goodall. That changed in Nov 2021.

The first SAGE meeting was 22 Jan. I did not attend SAGE until 11 Feb when I was invited. I think it would have been helpful for there to be Welsh representation before then. Because SAGE was a UK arrangement there was a need for Welsh specific scientific advice to be given to Welsh Ministers. That led to the setting up of TAC and TAG. These bodies are something you step up in an emergency rather than having as a standing arrangement.

In January 2020 it was increasingly likely that keeping the virus contained in China wasn't going to happen. I discussed this with my Director General Dr Andrew Goodall, and he suggested we take the issue to the Executive Committee of the Welsh Government. It was determined that we would continue to manage this as a health issue and keep an eye on what was happening. By that time there were no cases in Wales, I don't think there were any cases in the UK either.

It was late January before we were seeing the issues arising in Italy, but it was late February we were starting to see issues of capacity there. At that point I think it's fair to say we all got very worried about

the NHS capacity. Looking back, I think it was managed for too long as a health issue rather than as a cross-government issue, and that I think, was a mistake.

I'm not sure I would agree that containment had failed. The plan had containment as the initial step and then mitigation later, but we hadn't had a lot of cases in the UK at this point. Early in a pandemic, when you have sporadic cases, you have an aspiration that you can contain them by contact tracing around the patients. That was the initial approach we took in Wales. As you get more and more cases, then that becomes untenable and then you move to the delay phase. That became the coronavirus control plan.

Initially we thought that asymptomatic infection was unlikely but that proved not to be the case. People could be infected but not know it as they did not have symptoms. Asymptomatic transmission became apparent later on. The Welsh Government considered asymptomatic transmission but concluded that there was insufficient evidence upon which to base operational decisions. As the risk became understood, operational decisions were adapted accordingly. I don't know what operational decisions would have been managed differently under the precautionary principle of assuming asymptomatic transmission.

25 Feb - Welsh Cabinet meeting Vaughan Gething said there are no imported cases in the UK.

I wasn't at that meeting but if that was said, it wasn't correct.

With the benefit of hindsight, I would agree that banning mass gatherings so that emergency services are not displaced would seem to be a pragmatic approach, and I would also think that there may well have been an advantage in terms of public communication, because it would have given a signal to the public.

I was not consulted on the UK national lockdown. I don't recall a CMO discussion or formal change in our advice which led to this decision. I do think the Welsh Government should have been consulted.

Face Coverings: early in the pandemic when we were at risk of running out of PPE (and I stress at risk) we never actually ran out of PPE in hospitals in Wales, but my concern was that there could be a leaching of a scarce resource towards face coverings in the community. Use in the community would have been inappropriate because it wouldn't have provided very much protection and could potentially denude the health and social care system from the vital resources that they needed. I think it probably did weaken public messaging. When I look back, at all the time and energy that was spent in Wales thinking about face coverings, I do wonder whether it would have been a better decision to simply align with the UK. However, I believe my advice that face coverings should not be mandated was appropriate.

Circuit breaker: it was obvious that infection rates were rising fairly rapidly, so the advice from Public Health Wales and from TAC was quite clear that we needed to make an intervention. With all the interventions, I was recommending go early and go hard. The sooner it was implemented the better. The length of it was quite important, because Public Health Wales was advising that three weeks would have been preferable, but two weeks was the absolute minimum, and that's the advice I passed on to ministers. The Circuit Breaker certainly did have an impact in terms of reducing transmission, but the impact was relatively short lived.

Untested discharge to Care Homes: The common view was that care homes ought to be able to manage cases of infectious disease by isolating people within there. That's not an easy decision for ministers or

anybody to make. But it was in the context of the hospitals risking being overloaded and it was in the context of patients, elderly people who were not affected by Covid who were asymptomatic in hospital but potentially staying in hospital and becoming infected. So it was an absolute imperative to get people back to the safest place where they could be.

The infection was coming into care homes from many directions, it was coming in largely from the community, and so it was really important that we provided that general advice on infection control to the care homes so they could safely manage people coming in from the community and from hospitals. That was not an easy task for the care homes, but there was no safer alternative that we could see.

Dr Rob Orford (Chief Scientific Adviser for Health for Wales)

Part of my role is to ensure that the Welsh Government decisions related to healthcare are grounded in scientific evidence and best practices. I worked closely with Dr Frank Atherton (CMO)

22 January 2020 I emailed asking to have a read out from the first SAGE meeting. My first attendance was not until 11th Feb which was the 6th meeting and even then, I was invited as an observer so was not able to participate in the conversations. I found it slightly frustrating that it took time to access the group. When scientific information became available, it may have gone through civil servants or ministers before advisers' eyes. I would like to see unfiltered advice before it becomes public. Welsh members were permitted to join NERVTAG around May or June. I can't answer why it took so long. I think there were concerns about leaks to the media. One mistake I feel SAGE made was that economic advice did not play a significant role.

20 Feb I emailed regarding asymptomatic infection. We had information in SAGE from the cruise ship 30-50% of cases were asymptomatic or had mild symptoms. We didn't know until much later that asymptomatic transmission was happening.

16 March there was a discussion at SAGE that the doubling time was shorter than previously thought, and perhaps there were more cases in the community than had been picked up through surveillance. So the picture was pretty bleak at this time.

17 March advice from the First Minister of Wales was to limit non-essential contact, work from home where possible and avoid social venues. By that time, it was looking precarious, and we probably should have gone further then.

20 March TAC advice was that further control measures eg lockdown should be considered. At the time, the discussion was that we were possibly a couple of weeks behind London. Scientific papers suggest starting the lockdown a week earlier would have been better. With hindsight, if the UK had gone into lockdown on the 15th March that would have been better than the 23rd. A modelling study showed that introducing measures one week earlier would have reduced the number of cases in England by 745%.

With the benefit of hindsight, I think cancelling mass gatherings would have made sense because of the optics. From an epidemiological perspective then perhaps closing all bars at the same time to stop displacement activities. Whilst the risk of these individual events was negligible compared to the whole population where transmission happens all the time everywhere, allowing the events to go ahead gave the public the message that these events are okay.

The whole world was looking for tests for Covid, including UK Government, and the Welsh Government. Public Health Wales were concerned that an agreement had been struck with a company that wasn't honoured because of other power plays going on at UK level.

I did not advise on testing patients prior to transfer to care homes. There would be a huge demand for tests if everyone was getting tested. Around that time, we had in the region of a thousand tests a day available in Wales within hospitals generally. There are 105,000 staff in the NHS in Wales. 36,000 of those are nurses and 9,000 of those are doctors. There are 80,000 social care workers. There are 10,000 beds within the NHS and 23,000 residential beds.

On 18 September 2020 the ONS released data that demonstrated that 68% of deaths from Covid-19 between 2 March and 14 July 2020 were among disabled people.

21 September – SAGE recommended Circuit breaker. I was aware of that advice. Local interventions were in place for a period. I felt it made things more complicated, that you had to have more policies in place, across different local authorities. I think in hindsight, perhaps they weren't the best idea.

TAC had advised for firebreak. TAC said there needed to be a national intervention. There were lots of conversations about balancing harms. From a public health perspective, we did not consider there was any option than a firebreak. With the benefit of hindsight, earlier would have been better, it would have got the prevalence lower, but it did what it intended to do. It pushed the pandemic by 38 days and slowed the next period of growth for the next couple of weeks. If money had been made available by the UK Government to extend the firebreak, then perhaps we could have had a three-week firebreak that probably would have been better.

Dame Shan Morgan (Former Permanent Secretary to the Welsh Government)

Head of civil service within the Welsh Government.

The Welsh Government did not allow the use of WhatsApp on Welsh Government mobile phones. WhatsApp could be used on personal phones but not to conduct Welsh Government business. I took that to mean not making any decisions. I was not aware Welsh Ministers had WhatsApp enabled on their Senedd Phones. The instructions that came out to private offices was that we needed to maintain proper records, both for the Welsh Government but also for a future Inquiry.

The team were under such pressure and ministers under such pressure that it wasn't always possible to prepare a formal equality impact assessment. Childrens Rights Assessments were undertaken by the Welsh Government.

I would say honestly that I could have done more, I think it would probably have been a very good idea had I invited the chief exec of the WLGA to become a member of Ex Covid or at least come from time to time when there was an area of particular interest.

Dr Andrew Goodall (Permanent Secretary of the Welsh Government and former Director General Health and Social Services)

In the Welsh Government, the NHS Wales chief executive role is also the Director General of health and social services, so it's a role that is located in the civil service, but it has the responsibilities for the NHS. Within that role, the director general's responsibilities are supporting ministers, but it means that the NHS is line managed by the Welsh Government. I reported directly to the minister for health and social services. The Chief Medical Officer was accountable to me.

Dr Rob Orford (Chief Scientific Advisor for Health) found it difficult to get access to information from the UK networks with other UK CSAs. It is vital that significance of CSA for health role is formally recognised. I think that's an essential requirement for the devolved administration voices to be properly around the table and to make sure that we have that bridge in place.

We established the health and social care Covid-19 planning and response group. It gave us a way to anchor ourselves to the voices from the NHS and the care systems. The first meeting of that was on 20 February 2020, so that's some eight days before the first case in Wales. I do think that was early enough.

Capacity was certainly important during the first and second waves, I think the balance changed later on in the pandemic response, particularly when we had the benefits of vaccination. Making sure that the NHS was able to accommodate any Covid patients in the system, but equally to make sure that broader health services weren't overwhelmed so that they were able to carry on discharging their essential roles was really important.

We had generally good contact with officials in the Department of Health but some of the COBR oversight mechanisms were confidential and not for onward reporting unfortunately.

In March 2020 modelling for NHS Wales projected a necessity for 900 critical care beds and an additional 10,000 system wide beds at the point of peak demand. Existing capacity within NHS Wales was only 152 critical care beds and 7839 system wide beds. The Reasonable Worst Case Scenario modelling indicated that the NHS Wales capacity would be significantly exceeded as over half the population would become symptomatic and a high proportion would require hospital care.

The first case in Wales was on the 28th and that acted as a trigger. There is a danger of seeing the Reasonable Worst-Case Scenarios as the forecast, that they are likely and that they will happen. In fact,

our swine flu experience told us different, and that we couldn't rely necessarily on the Reasonable Worst-Case Scenarios. I think the reality for us in March, though, was that the data that we were seeing progressed both internationally and on a UK basis and was genuinely showing the exponential growth. It was showing that the Reasonable Worst-Case Scenario was actually possible. I think it was that realisation that changed the extent of our planning at that time.

In February 2020, in the background of our arrangements, we had been updating extreme surge guidance just as part of emergency planning. Throughout the whole of the pandemic response we never had a need to introduce that emergency surge guidance but it would have given criteria to make choices in the most difficult of circumstances. The person making that decision being the individual clinician. As an example, we had done some work through the Chief Nursing Officer in Wales on criteria that may need to be used in critical care for nursing staff ratios.

13 March: announcement of measures such as the suspension of non-urgent outpatient and surgical care in Wales, expedited discharge of vulnerable patients from acute and community hospitals, suspending the current protocol which gives the right to a choice of Home. These were directed nationally to assist the capacity requirements for the system. The delivery of them was a local matter. There was national direction on these, they were intended to give permission to the system to enable its preparations and to ensure that the NHS particularly was not going to be overwhelmed.

Equality impact assessments were not carried out. The speed and the exponential growth of the virus meant that we were stepping in very quickly, it was an unprecedented action that we were taking, and we were needing to discharge that responsibility very, very quickly. The context here was that we were focusing on planning for a 13-week period of time, if we'd known that the pandemic was going to go on for two and a half years we may well have adjusted some of these decisions, but they were pretty essential to make sure that the NHS was going to be available.

There are constraints on us about what can be reported, when and how, things that come through the COBR mechanisms of course have a level of confidentiality around them. I think it would have helped to have been able to be more transparent with the population, certainly through March and at the end of February, but that was a judgement that the minister made at the time, and I do think it was the right one.

The direction to expedite discharge of vulnerable patients from acute and community hospitals was a ministerial decision in line with advice. It was intended to help the NHS to create capacity. Concerns were raised fairly quickly. At the time we were not aware of the risk of asymptomatic transmission. I didn't recall the SAGE planning assumptions that said Asymptomatic transmission couldn't be ruled out. We would have some expectations for care homes to be able to accommodate isolation procedures. In retrospect, given what we know now about the asymptomatic transmission yes of course that could have been targeted differently.

The CMO wanted to ensure there was support for vulnerable groups. But the clinical criteria and trying to reconcile the various databases to identify a list of patients across England, Scotland, Northern Ireland or Wales, all of which have different systems, was an extraordinarily technical and complex task.

Running out of PPE was a genuine concern. The pandemic stocks that we'd put in place as a contingency allowed us to manoeuvre our way through those first weeks with around 10 million items that had been made available. But we needed to ensure that there was a good supply chain and we were able to achieve that. My role was really to secure that supply at a national level, but what we also had to do is change the way in which we were issuing supplies across Wales, literally to thousands of sites, rather than the few hundred that would have been the reality for the NHS in Wales.

It was almost immediately clear that testing capacity was limited. We didn't have the laboratory structure available, we had 1800 tests a day available in mid-March. We took advice on who should be prioritised for testing. As you would expect it was done from a healthcare professional perspective. Discharge of patients from hospitals to care homes without testing was based on the knowledge that we had at the time. What happens at the front door of the hospital depends on what happens at discharge. You need patients to be discharged on a daily basis to be able to maintain patient flow.

I was in favour of the firebreak. It was advised from SAGE. The firebreak was an important intervention. It was more limited than maybe ministers had wanted but I do think the firebreak had the impact that was broadly intended because it reset the virus by about 38 days. I think a longer firebreak would have been preferable, but there were genuinely funding limitations from a Welsh Government perspective and ministers of course were very mindful of the wider harms that needed to be determined outside of the NHS itself.

We had 10 million items of PPE in storage. We had 13 weeks of supply but that ran down much more quickly than expected. Over time we expanded the provision of PPE to the care sector very significantly, out of 2 billion items that we provided across Wales about 800 million were provided to care homes so about a third of the overall response.

Dr Tracey Cooper (Chief Executive of Public Health Wales)

Jan to March we were the sole organisation at that point undertaking contact tracing, mainly initially for people who were coming back into the country, returning travellers. We established a port and borders cell. That activity expanded as restrictions were brought into international travel. We received the data from the Home Office around returning travellers and would contact individuals, giving them tailored advice.

We did find ourselves on occasion working beyond our skillset or our mandate, and some of that was because there was no pre-existing organisation or entity doing an action that was needed. I don't know who, but someone decided to set up a mass sampling centre in Cardiff but didn't tell PHW or the Welsh Government so we had to establish that overnight.

Our role wasn't to do the swabbing part of testing, although we did it for the first two months or so to help health boards. Our role was the diagnostic elements of testing. We had the staff and the machines, the biggest challenge was getting the chemicals to do the tests.

I would agree that at the start of 2020 the health protection services in Public Health Wales were under-powered. In 2018 we flagged to the Chief Medical Officer and Welsh Government the concerns that we had that we needed to build more resilience around our health protection, microbiology surveillance services. In 2019 we put a business case in to expand health protection microbiology and surveillance services in order to build pandemic preparedness and resilience, and that was approved in part around September 2019.

The point of going from containment to delay on 13 March and then the lockdown, was that we didn't have the capacity to cope with all of the contact tracing, it was exponential. When we moved into lockdown, it did calm things down for us, and it gave us an opportunity to really take stock.

In light of the evidence of asymptomatic transmission I do not accept the original advice on not testing patients prior to discharge to care homes. If someone had a fever or a continuous cough, that was the indication for tests. If someone had a negative test it didn't mean that they weren't incubating Covid. We only had about a thousand tests per day so it was a challenging time.

Dr Quentin Sandifer (Consultant Adviser for Pandemic and International Health for Public Health Wales)

I attended very few decision-making committees, groups or forums dealing with or impacting upon the Welsh Government's response to Covid-19. I attended very few ministerial meetings. I had direct and very regular communication throughout the pandemic response with the Chief Medical Officer.

We did not have in Wales a High-Consequence Infectious Diseases Unit. All our acute hospitals had isolation facilities, but an audit conducted in 2017 suggested that not all those isolation units satisfied our expectations. This meant we would have to move a patient to a unit in England.

22 January 2020 Public Health Wales invoked its emergency plan at an enhanced level. PHE had been responding at enhanced level since 9 January. I don't think PHW had to do the same necessarily. In the face of a potential high-consequence infectious disease alert, it was entirely correct that PHE would immediately go to an enhanced level. The first suspected case in Wales was not until 15 January. Public Health Wales had its first meeting with the Chief Medical Officer of Wales on 21 January 2020.

I don't think if we had escalated it from enhanced to a major incident the Welsh Government would have taken things more seriously. A Public Health Wales response plan directs our internal Public Health Wales actions. If we had gone to a major incident, we were just simply saying we desperately need to mobilise more resources internally. Well, we were doing that anyway, and I don't think that that would have

signalled to anyone outside the organisation that they in turn ought to take different action. I think it would only simply have confused the situation. We were responding, consistent with Public Health England, at enhanced level. If we had it might have caused confusion. There was one confirmed case in Europe so people would have asked what we were doing.

31 January felt like a seminal moment. The Chief Medical Officer of the UK announced the first two cases in the UK. It just felt to me like this was an inflection point in the whole pandemic. I personally was starting to get very concerned now about the extent to which I could see beyond the Chief Medical Officer a response from Welsh Government.

10 February 2020 the Chief Medical Officer for Wales issued a letter to health board chief executives requesting that every health board develop community assessment and testing plans and that each health board must have coronavirus testing units separate from emergency departments, and that those arrangements were to be operational as soon as possible. This was in response to our frustration and concern at the pace at which the health boards were putting together their sampling capacity.

25 February I emailed saying that we needed the same level of urgency as was happening in Public Health England and the DHSC. I just felt that the response that I was seeing in Wales at that time to the specific actions that Public Health England were taking was not commensurate and that we needed more urgency.

23 March email from me saying “above all else I am really worried that national politics could trump public safety and need in Wales and we end up losing out badly in Wales."

We were in discussion with Public Health England about access to tests from Roche. I thought that there was an agreement for 5,000 tests to come to Wales. However, we didn't have that in writing. My concern at this stage was that we were going to lose those tests. I was probably stepping out of line by speculating whether there was anything at UK Government level that might be behind that and emphasising my concern about the implications of losing that test capacity on public safety and need in Wales.

The Welsh Government wrote to all the Health Boards requesting their plans. It was clear that further work was required. I was concerned that our health boards' public health functions were not necessarily geared up for what might come in the winter. I think what was missing in the first few weeks from 8 January until 20 February was national strategic leadership and co-ordination from Welsh Government. I stand by that.

Shavanah Taj (General Secretary, Wales Trade Union Congress)

Some of the differences here specifically was that the Welsh Government made sure that in their Covid guidance it was made clear that employers should be consulting with their trade unions when it came to workplace risk assessments. Typically, we met Ministers after Cabinet had made decisions to discuss how they would be implemented. Our discussions were before any public announcement so we could point out gaps and discuss messaging and need for guidance that all workers could access. Difficulties were

caused by the fact that the Welsh Government don't have even now a direct responsibility for employment rights.

On 14 March the TUC wrote to the Welsh Governmentt regarding four key concerns that the Wales TUC had at that point. Those concerns were namely the procurement of PPE, the dissemination of workplace safety guidance, the adequacy of sick pay and support for those who were suffering hardship. We had to keep pressing regarding PPE.

Dr Chris Llewelyn (Chief Executive of the Welsh Local Government Association)

Decisions about how services are run and provided locally need to be made as close to the point of delivery as possible.

The meeting on 12 March 2020 was the first local government meeting where Covid-19 was discussed with the Welsh Government. There had been internal discussions prior to that. It would be fair to say there was a sense of disquiet and maybe an expectation that there would be a greater sense of urgency.

Local government delivers over 700 services every day. Everybody in this room has used local government services. Whatever the circumstances, authorities understand how to deliver services, and that understanding can inform policymaking and the sooner I think authorities would have been involved in this instance then that would have saved time and would have resulted in more effective policymaking. I think we should have been part of the strategic decision-making, in effect the experience of delivering services should have informed the strategic thinking and decision-making.

Information could have been shared more fully earlier. Local government needs to be engaged at a point when it's possible to influence and shape policy rather than being informed when policy has been agreed. There was experience and capacity with, within local government, had it been used at an earlier point then it would have led to better regulations and better guidance and would have probably saved time.

As the year progressed engagements between elected officials improved and more data was shared with us. As local lockdowns and other arrangements of the October firebreak were discussed, increasingly relevant evidence was shared with local authorities as well so that leaders could be part of an informed decision-making process.

There was a general sense that the needs of social care staff as a whole weren't being taken into account, when it came to testing arrangements and the provision of PPE. There was a sense within the workforce that they were being neglected and weren't taken into consideration and account in the same way as other service areas. They weren't appreciated as fully as they should have done, that there was an issue of parity of esteem with other healthcare workers. I think everybody knows the rewards in the sector are very modest.

WLGA raised the issue of not testing before discharge from hospital to care homes. It was something that was discussed on a regular basis in our meetings with ministers.

I think the Civil Contingencies Act is outdated and is no longer fit for purpose and needs to be reviewed urgently. The Civil Contingencies Act is designed for one-off major incidents. Nobody envisaged a global pandemic of the nature and scale of the Covid crisis. It isn't appropriate for a crisis of the duration of Covid and significantly it doesn't give elected members at any level enough of an involvement in the process as an organisation which promotes the primacy of politics, of elected members taking decisions and being held to account. The Civil Contingencies Act and those arrangements that sit underneath don't take that into account.

Reg Kilpatrick (Director General of the Covid Recovery and Local Government Group)

4 February Civil Contingencies Group meeting. The meeting was triggered by my national pessimism as it seemed like there was the potential for it to come to the UK. The partners were engaging on a daily basis from 4th Feb both by meeting and by providing information into the system. I think the distinction between communication and consultation in the circumstances of the early days of Covid is a very thin distinction. So in practice every engagement that I, my team and ministers had with the WLGA, whether that was at leader level or at official level, were in effect consultations.

I would dispute the WLGA assertion that we didn't consult, I think we had an extraordinary level of consultation. I do accept that the engagement wasn't always early enough. It could have been better, it most certainly would have been better had we had more information to share from the UK Government. We were quite constrained in what we could say, because the flow from the UK Government was at times limited, and particularly, you know, in the run-up to the first lockdown.

Jane Runeckles (Head of the Welsh Government's team of Special Advisers)

The tensions between the actions taken by the Welsh Government and the actions taken by the UK Government became more and more obvious.

I attended almost every Cabinet meeting, ministerial call and meeting with the UK Government and the other devolved governments that the First Minister attended. I also attended numerous internal Welsh Government meetings. I attended meetings as an observer.

The First Minister attended his first COBR meeting on 1 Feb. Previously, the Welsh Government was represented at COBR by the Minister for Health and Social Care. Covid-19 was not discussed by the Welsh Cabinet until 25 February. The Minister for health kept the First Minister updated informally, as did Dr Frank Atherton.

Given what we know I agree that more stringent action could and should have been taken sooner.

A number of things happened that put pressure on the relationship between the UK and Welsh Government, including the opening of a test centre in Cardiff City football stadium by the UK Government without any consultation with the Welsh Government. That created significant difficulties with data.

The First Minister did not see COBR papers until very close to the time of the meetings, and it was often unclear what the agenda would be until just before the start of those meetings.

The contact between the PM and the First Minister was infrequent, and I believe the First Minister had a genuine, sincerely held concern that some of the actions of the United Kingdom Government in relation to the way they had handled some of the earlier period was a genuine threat to the future of the United Kingdom. The meetings with Gove were not a suitable substitute. They were an informal opportunity for the First Ministers and the Deputy First Minister of Northern Ireland to explore issues, but they were not meetings where significant decisions at a four nations basis were taken place.

In May 2020 the First Minister wrote to Sir Patrick Vallance as chair of SAGE outlining the desire of the Welsh Government to engage more actively in the work that SAGE was undertaking. Some of the work that was being undertaken by SAGE on modelling in relation to easements from the lockdown was being undertaken based on a set of questions that were being asked to them by the UK Government Cabinet Office, which reflected very specific England focused questions, eg different term dates in Scotland being a particular consideration, but it was those kinds of issues that we were concerned about.

Toby Mason (Head of Strategic Communications for the Welsh Government)

Civil Servant, not a political appointment.

Engagement with the UK Government and other devolved Governments was an absolutely vital part of my and my team's role. There was the potential for confusion due to different rules in different parts of the UK. We had to ensure that people in Wales understood the rules that applied to them and what the government's messages were.

There was liaison at all levels of the communications teams throughout the pandemic. I had contact with the UK Government's director of communications. Our health communications teams were very closely involved with DHSC, Public Health England and the other devolved administrations. But the critical point was that once the divergence took place, we formalised a four nations communications group of senior leaders.

We had no particular issue with UK Government communications and campaigns running in Wales so long as they were reinforcing the key behaviours that people needed to keep the prevalence of the virus down.

Both the First Minister and the First Minister of Scotland expressed opposition to the Stay Alert messaging at the COBR meeting which took place on the afternoon of 10 May 2020, and expressed a view that campaign material featuring this should not be run by the UK Government in either Scotland or Wales, given the key message in those nations at that point was to stay home. We were not given advance notice of the stay alert campaign prior to its introduction in England.

One area of frustration was quite frequently the UK Government, the Downing Street briefings, even when they were on devolved matters, barely referenced England and of course those were broadcast across the whole of Wales. We made strenuous efforts at every level including First Ministerial to try and appeal to them to be clearer.

Bilingualism. We have a statutory responsibility as a government to communicate in both languages and not treat one less than the other.

Simon Hart MP (Parliamentary Secretary to the Treasury (Chief Whip) and former Secretary of State for Wales)

I was responsible for representing Wales' interests in matters that are reserved to the UK Government. I was responsible for ensuring that the concerns and priorities of Wales are considered in the decision-making of the UK Government.

I attended COBR meetings during the pandemic where I served as the voice of Wales. I spoke with the First Minister rarely but we met when we needed to. I do not disagree with the First Minister's view that I was peripheral to his interaction with the UK Government. The point of contact was Chancellor of Duchy of Lancaster (Michael Gove).

It wasn't until mid-March that the gears of Government changed and the focus shifted to managing the pandemic. With the benefit of hindsight, could we have done things differently, could we have done things faster. We might have made some profound mistakes but the desire to try and get this right was very evident very early on, as soon as people became aware of what was heading our way.

If there was any one decision I would do differently it would be the decision to use the Public Health Act rather than the Civil Contingencies Act. It may not have changed the outcome, but we would have been able to present a much more consistent and much simpler set of proposals, restrictions and principles than we were able to do subsequently.

It was inevitable, once we had the three or four different administrations all with slightly different ideas about how to deal with this, but a population which was very fluid, this was going to lead to problems. I found it increasingly disturbing that we were looking at the problem through the lens of a political boundary, geographical boundary between England and Wales, rather than looking at the population and the way the population and the economy crosses the border.

In the absence of any evidence to suggest that the divergence was going to have the effect that it was argued it would have, it was difficult to reach any other conclusion other than that it was motivated by a desire to be different.