UK COVID-19 INQUIRY
MODULE 2B

FIRST STATEMENT OF CAROL SHILLABEER

I, Carol Shillabeer, provide this statement in response to a request by the Inquiry under Rule 9 of the Inquiry Rules 2006 dated 19th May 2023. Insofar as the contents of this statement are within my personal knowledge, they are true, and, insofar as the contents of it are not within my personal knowledge, they are true to the best of my knowledge and belief.

Introduction and Overview

1. My qualifications, career history and professional expertise may be summarised as follows:

    a. I am a Registered Nurse with the Nursing and Midwifery Council (**"NMC"**). I was also a recipient of a Florence Nightingale Foundation Leadership Scholarship for Registered Nurses in 2012 and I have a master's degree in Health Service Management from Cardiff University.

    b. I have particular professional expertise in clinical leadership and management, general management, programme management, and in Maternity, Children's, Mental Health and Community Care.

    c. My clinical nursing and nursing leadership roles to date are as follows:

        i. Between 1990 and 1994 I was a Staff Nurse in Renal & General Medicine;

        ii. Between 1994 and 1997 I was a Night Nurse Practitioner;

        iii. Between 1997 and 1998 I was a Medical Ward Manager;

        iv. Between 1998 and 2000 I was a Senior Surgical Nurse and a Surgical Directorate Manager;

        v. Between 2000 and 2004 I was Head of Nursing (Medical);

vi. Between 2004 and 2008 I was Associate Director of Nursing;

vii. Between 2008 and 2009 I was General Manager of Women & Children's Services;

viii. Between 2009 and 2015 I was Director of Nursing at Powys Teaching Local Health Board (**"Powys THB"**);

ix. Since 2015 I have been Chief Executive of Powys THB; and

x. Since May 2023 I have been on secondment as the Chief Executive of Betsi Cadwaladr University Health Board.

d. I have also had further roles, as follows:

i. Between 2002 and 2006 I was a Panel Member on the Conduct & Competence Committee of the NMC; and

ii. Between 2013 and 2015 I was a Council Member & Vice Chair of the NMC (UK Registrar for Nursing & Midwifery).

2. Powys THB is one of seven integrated Health Boards in Wales. It provides health services for the approximately 133,000 people living in Powys, a large and very rural county of approximately 2,000 square miles. The very rural nature of Powys means that the majority of local services are provided locally, through GPs and other primary care services, community hospitals and community services. Further, there is an insufficient critical mass of people locally to provide a District General Hospital within Powys and so Powys THB also commissions services for Powys residents to receive acute hospital services in hospitals outside the county in both England and Wales. The core purpose of Powys THB is to help to improve health and wellbeing among the population of Powys (including by working in partnership with others) and to plan, commission and provide high quality healthcare services to the population of Powys.

3. As Chief Executive of Powys THB, I was the Accountable Officer and the operational leader of the organisation, with responsibility for leadership and management of the Health Board. This included, as appropriate, developing strategies and plans to meet

the purpose of the Health Board, overseeing and leading the implementation of relevant strategies and plans, working to enable the achievement of relevant standards (including quality, financial and workplace), and making a broad contribution to the collective leadership of NHS Wales.

4. The pandemic did not change the role or core purpose of Powys THB, or my job description, but the changed circumstances meant that my role focused on the emergency response to this global pandemic. In addition, during the course of the pandemic, at the request of the Welsh Government I took on the role of chair of the COVID-19 Vaccination Programme, acting as a system leader, between January 2021 and November 2022.

5. The interactions between Powys THB and the Welsh Government involved:

    a. Professional Appraisal and Development Reviews, which took place annually;

    b. Formal accountability arrangements for performance and delivery, including Joint Executive Team meetings, which routinely took place every six months;

    c. Collective Leadership Forums, including NHS Leadership Board meetings, which took place every month; and

    d. Service Touchpoint Meetings to discuss topical service pressures, which took place weekly on Monday mornings.

6. During the course of the pandemic, there were modifications and evolutions, according to the stage of the pandemic, in relation to the interactions between Powys THB and the Welsh Government. In particular:

    a. Modifications were made to the NHS Leadership Board meetings, with focus being placed on the emergency response to the pandemic and routine business not being conducted in these meetings;

    b. The frequency of Service Touchpoint Meetings was increased to at least twice a week and these meetings also focused on the emergency response to the pandemic; and

c. Additional meetings were convened, including, in due course, meetings relating to the Covid-19 Vaccination Programme.

Initial response to the pandemic: January to March 2020

7. I first became aware of Covid-19 in my official capacity in January 2020, in a briefing via conference call by the Medical Director of Public Health Wales, Dr Quentin Sandifer, to all Health Boards and NHS Trusts. I recall that this briefing centred on the emergence of a virus connected to China and a concern was raised that Cardiff University could be a central focus point, in light of the number of Chinese students there. I do not believe that any documents were provided to us for this meeting.

8. Between this time and mid-March 2020, the weekly Service Touchpoint meetings continued, and additional conference calls also took place, with the emergent picture, insofar as it could be ascertained, being shared. The focus of these meetings increasingly turned to the emergence and then the significant preparation required for managing the risks related to the global spread of a virus, which became the pandemic.

9. On Friday 13th March 2020 at about 9am a call took place between me and Dr Andrew Goodall, the NHS Wales Chief Executive / Director General of Health and Social Services at the time, to discuss next steps of preparation and escalation. At this call, Dr Goodall requested the professional views of the Chief Executives of NHS bodies in relation to the level of 'normal' operating that could feasibly continue, and requested suggestions as to steps to be taken in the short term (i.e. in the next few days or weeks).

10. Immediately after this call, I liaised with the members of the NHS bodies' Chief Executive Group by email and worked with them to prepare a letter to send to Dr Goodall. We had to work at speed owing to the urgency of the situation. After an agreed letter was completed, it was sent by me to Dr Goodall under cover of email at 12.02pm on the same day. In this letter, I set out the professional view of the NHS Bodies' Chief Executive Group. I stated that we believed that there was a small window of opportunity to use the current resources that we had to activate our planning for the best possible state of readiness for the significant demand that we anticipated would be placed on the health service, that an immediate decision should be taken to reprioritise clinical and support services to balance the needs of all of the population along with the urgent requirements of the immediate Covid-19 response, and that clear and confident

messaging to the public and to the workforce across primary and secondary care was key. The letter concluded as follows: *"Taking all currently known factors into account, we are in collective agreement that an immediate decision of the reprioritisation of clinical and support services is not only advisable but necessary. We recognise that this may require further discussion at our call this afternoon, however we hope our view is helpful for consideration at this critical time."* This letter and covering email are exhibited to this statement as **[CS/1 - INQ000282360, CS/1a - INQ000282362]**.

11. Additionally, at 11.54am on Friday 13th March 2020, the latest NHS Wales Covid-19 spreadsheets were shared by email by the Welsh Government with the NHS bodies' Chief Executives, including me, and Directors of Planning, on the basis that we needed to have some appreciation of the scenarios relating to the trajectory of the pandemic. This information was marked 'Official Sensitive'. It gave an indication of the anticipated scale of Covid-19 infection should there be no substantial action to prevent transmission. It was my clear view on the basis of this information that the scale was such that it would have overwhelmed the capacity of the NHS. This information and covering email are exhibited to this statement as **[CS/2 - INQ000282363, CS/2a - INQ000282366, CS/2b - INQ000282367]**.

12. At 2pm that day, a conference call took place between Dr Goodall and the NHS bodies' Chief Executives. As to this call, it was outlined by Dr Goodall that the Welsh Government would likely make a statement regarding re-prioritisation of NHS work to further focus on preparedness.

13. At a press conference at approximately 4pm later that day, the First Minister announced that he had taken steps to direct the NHS in Wales to stand down non-urgent NHS work. Powys THB started to cancel routine work as soon as this announcement was made. I believe that the view set out in the letter of the NHS bodies' Chief Executives that was sent to Dr Goodall that day was taken into consideration by the Welsh Government in relation to its decision-making at this time, particularly where the substantive view provided in the letter seemed to be reflected in the statement made by the First Minister, though I do not have evidence to prove that it was taken into consideration.

14. Insofar as I can comment through my interactions with Dr Goodall, I consider that the Welsh Government took the threat of Covid-19 seriously. However, I must stress that

I was not privy to the full extent of the information available to the Welsh Government, or to the full content of the Welsh Government's discussions and preparation.

15. It is my view that, in the absence of other feasible and life-saving strategies, it was essential to take action to dramatically reduce human-to-human contact and transmission of the virus at this time. Further, with limited options available at this time, I think that from a public health perspective the need for a lockdown was clear in order to reduce transmission and infection and the risk of the NHS being overwhelmed. I note that the letter of the NHS bodies' Chief Executives made its recommendations on 13th March 2020, however it was 10 days from this until the Prime Minster announced lockdown measures on 23rd March 2020. This seemed longer than would have been required in the circumstances. However, I should also note that I offer this view from my own professional perspective, and I did not have all the information available to the decision-makers at the time.

16. As to the length of the lockdown, I think that the key question for decision-makers would have been whether anything had changed fundamentally to enable the restrictions to be lifted. However, again I should also note that I offer these views from my own professional perspective, and I did not have all the information available to the decision-makers at the time.

17. I have no specific comment in relation to decisions made by the Welsh Government in respect of international travel and border control. I note that there are no airports or ports in Powys.

18. I was not privy to the full content of the agreements between the Welsh and UK Governments in terms of scope and delegation of decision-making in circumstances where this was a civil contingencies matter. I note that whilst health is devolved in Wales, this pandemic was not just a health emergency, but also a civil emergency.

Engagement with the Welsh Government

19. My role did not involve providing advice to the Welsh Government and I did not attend, or provide advice or briefings to, decision-making committees dealing with or impacting upon the Welsh Government's response to the pandemic. Rather, in my interactions with the Welsh Government I provided a professional Chief Executive view, often on

behalf of NHS bodies' Chief Executives through my role as lead Chief Executive of the Chief Executives' peer group.

20. As to my contact with the Welsh Government and my involvement in groups or forums relating to the Welsh Government's response to the pandemic:

    a. I was lead Chief Executive of the NHS bodies' Chief Executives' peer group and convened its meetings. This group was active and generally offered professional perspectives on current status. The meetings took place several times a week, and sometimes also included follow-up emails. The meetings did not usually involve any Welsh Government officials, except for when, on occasion, an official was invited to attend to provide information to us.

    b. I attended Covid-19 catch-up meetings, which would be convened at least once a week by Dr Goodall and would include some of his Welsh Government team. On occasion, for example, the Chief Medical Officer or the Chief Scientific Officer would attend. However, this group did not involve any Ministers.

    c. I also had regular contact approximately once or twice a week with the NHS Wales Chief Executive / Director General in relation to liaison between Welsh Government and the Chief Executives' peer group. This largely involved information-sharing and providing feedback regarding live and active issues raised by the Chief Executives.

    d. In due course, I also chaired the COVID-19 Vaccination Programme Board. As to this, I was contacted by the NHS Wales Chief Executive / Director General on 11th January 2021 to request that I become involved in the programme. My role was to provide a system leadership perspective in relation to the programme and its development and delivery. In the early weeks, the Health Minister occasionally attended meetings of the COVID-19 Vaccination Programme Board, although not regularly. I was not party to the decision that mass vaccination nationally should be undertaken.

    e. In addition, the local authority in Powys jointly with Powys THB was responsible for establishing the Test, Trace and Protect (**"TTP"**) Programme in June 2020. This involved regular escalation and review meetings. These were initially held three times per week, and, in due course, the frequency was stepped down to

weekly and then monthly meetings. The core participants were me, the Chief Executive of the local authority, the Director of Public Protection of the local authority and the Director of Public Health of Powys THB. No Welsh Government officials were involved.

21. I believe that there was positive co-working and regular contact between the NHS bodies' Chief Executives and the NHS Wales Chief Executive / Director General and that views and perspectives were sought on key issues in a professional context. I also believe that my executive colleagues in Powys had good access to their counterpart policy colleagues. However, earlier clarification of guidance and release of policy changes would have been welcome. In relation to care homes, the guidance changed very rapidly, and it was not always easy to anticipate the next set of guidance.

22. The main mechanisms by which Powys THB would collect and provide data and statistics to the Welsh Government were through testing statistics, mortality statistics and data relating to the COVID-19 Vaccination Programme. As to the development of the Welsh Government's requirements over the course of the pandemic:

    a. In relation to testing statistics, early in the days of the testing regime, in early March 2020, there were issues in relation to cross border cases and who was reporting what to whom. For example, Public Health England might report the test result of someone who could be a Powys patient in Hereford. To address this, Public Health Wales implemented cross-border guidance.

    b. In relation to mortality statistics, there were issues in the early days of the pandemic in relation to Powys patients placed in an acute setting. In particular, owing to the rural nature of Powys THB and its facilities (which did not include a district hospital), very sick patients in Powys would go to an acute hospital across the border, usually in Shrewsbury or Hereford, and if they died there, it was unclear that they would be properly recorded as deaths of Powys residents. To address this, I believe that the Office of National Statistics enabled its system to ensure the recording of both the place of death and the place of normal residency for deaths relating to Covid-19. In addition, we also set up local systems to link with the district general hospitals to enable information to be exchanged.

c. In relation to the COVID-19 Vaccination Programme, a Welsh Immunisation System (**"WIS"**) system was rapidly developed, which collected data quickly and efficiently and worked very well for what was required. This ran alongside the TTP system with all the local authorities and Health Boards utilising this system. This reflected a strength of Wales, where collective working enabled a flexible and agile approach. Digital Health and Care Wales led these national IT, data and digital developments.

23. As to whether Powys THB had sufficient access to Wales-specific modelling over the course of the pandemic to inform the information and data that it was providing to the Welsh Government, I note that in the early days of the pandemic there was some concern about data being shared from the Welsh Government to health bodies. The NHS Wales Chief Executive / Director General however took the decision to share data via the Official Sensitive information provided to us in March 2020, to enable effective planning and to allow NHS bodies' Chief Executives to provide a professional perspective to the NHS Wales Chief Executive / Director General on the ability of the service to respond to relevant scenarios (as discussed above). As the pandemic developed, the modelling came through more regularly.

24. Powys THB was able to ask questions of the Welsh Government officials by way of the catch-up meetings and would often receive an overview by the Chief Scientific Officer to help interpret graphs and charts, enabling discussion regarding the ability to respond to developments. Although the national scenario data was helpful, further local analysis was needed in order to adequately model potential local impact. From my perspective, for the future, I believe that it would be sensible for greater emphasis to be placed on scenario planning, particularly on modelling, to assist in ensuring that the best possible preparation is done against a range of scenarios.

Non-pharmaceutical interventions ("NPIs")

25. I had no role in relation to decision-making concerning the imposition of, easing of, or exceptions to, the NPIs referenced by the Inquiry. In this regard, the role of the Health Boards was to implement relevant NPIs in relation to their service population and staff, particularly in relation to use of face coverings, restrictions on mass gatherings, self-isolation requirements, supporting local authorities in the closure and opening of schools and social distancing. I did not provide advice in this regard (and neither did

any other representative of Powys THB), but through my role within the NHS bodies' Chief Executive forum I conveyed the professional views of Chief Executives.

26. I did not attend meetings with the Welsh Government to discuss NPIs specifically. In catch-up meeting with the NHS Wales Chief Executive / Director General, the Welsh Government's consideration of NPIs was highlighted, however there were no formal requests for a professional view on this matter.

27. There were frequent peer group discussions and contact between the Chief Executives and the NHS Wales Chief Executive / Director General. I was not privy to all the information that was available relating to the lockdowns and other NPIs or where the balance of risk lay. However, I note that when an issue became clearer in relation to the needs of children with neurodevelopmental issues and their access to School Hubs, the Government changed its approach, resulting in children with neurodevelopmental conditions being supported in attending school or nursery and being allowed to travel by car to access outdoor exercise during lockdown. This meant that during the lockdown of November 2020, children with neurodevelopmental conditions were included in the eligibility criteria to attend School Hubs.

Local lockdowns and restrictions

28. As to this, I have no specific comment, as Powys was never put into a local lockdown.

Care Homes

29. Powys THB first became aware that asymptomatic patients would be discharged from hospital to care homes without a Covid-19 test on 20th March 2020, when it received the official guidance applicable to England on Covid-19 hospital discharge service requirements, which it understood at the time would also apply in Wales. I understand that further official guidance specifically applicable to Wales on Covid-19 hospital discharge service requirements was published on 7th April 2020, although I do not recall when that guidance was received by Powys THB.

30. The only documentation relating to the decision to discharge asymptomatic patients into care homes that Powys THB has is the official guidance. Powys THB does not have any additional documentation relating to the Welsh Government's decision to test all hospital patients before discharging them to care homes in late April 2020.

31. Neither I nor representatives of Powys THB were consulted in relation to the core decisions taken by the Welsh Government in respect of care homes whilst I was Chief Executive of Powys THB. The usual practice in normal times would be for draft guidance to be issued for views to be provided, and it would be normal practice for Health Boards to offer a view, before finalisation by the Welsh Government and promulgation of the final guidance. However, in the circumstances of the pandemic, I think that this process would have been too slow, and I also think that instead of a formal consultation process conversations with professionals would probably have taken place. However, I was not party to these. I should also note that the Health Boards are not speciality experts in relation to decision-making in this regard. Recognising the other sources of expertise relating to matters of testing, wider surveillance and infection, prevention and control, as well as the balance of these element with wider factors, the main role of the Health Board was to take forward the implementation of such guidance with other partners including, in this case, local authorities.

32. The most significant decisions, in my view, include the testing guidance as described above; the provision of PPE to the care sector and specifically the establishment of a distribution network via the NHS Wales Shared Services partnership, a well-tested and effective means of distributing NHS equipment in Wales; and the decision to provide financial support to care homes in order to maintain their viability where they had significant additional costs and reduced income. In relation to the financial support for care homes, I was asked for an informal view in relation to this matter, as the NHS is a significant commissioner of care from the care sector. The feedback to Welsh Government officials was that financial support was necessary to enable the care sector to maintain stability during this period.

Impact on hospitals

33. As to the core decisions made by the Welsh Government regards hospital discharge, use of DNAR orders and management of hospital capacity, in my view, these were as follows:

    a. The approaches to testing for people returning to care homes, as referred to above.

b. In addition, the approaches to testing for people being admitted into hospital and those who were due to undergo planned care operations. This was a key decision in order to prevent and/or manage the risks relating to nosocomial infection. The guidance relating to this was issued via email and the dynamic situation and short notice of guidance changes required Health Boards to respond quickly, with the usual consultation mechanisms not being in place.

c. In relation to the DNAR policy, the Health Board had a well-established DNAR policy in place prior to the pandemic. This continued to be applied in Powys throughout the pandemic period.

d. In relation to hospital capacity, the Welsh Government asked each Health Board to undertake an assessment of capacity and develop surge capacity plans in order to manage and mitigate the demand that had been outlined in the scenarios shared.

34. By way of context, Powys THB had a number of community hospital beds (i.e. beds in hospitals that support people who are recovering and no longer need a bed in an acute hospital), but it was anticipated that these would not be sufficient for the potential increase in demand. Therefore, planning was done in relation to field hospitals. In relation to this, through our planning work we knew what the trigger point would be to activate field hospitals and how long it would take. However, it never proved necessary for them to be activated.

Test, Trace, Protect

35. The overall role of the Health Board in relation to TTP was to work with the Welsh Government in terms of testing, and, in relation to the tracing elements, to work closely with the local authority and the Welsh Government in order to implement effective mechanisms for both testing and tracing. It was my understanding that the UK Government was solely leading on and directing decision-making in relation to testing centres and I am not aware of any consultation between the UK Government and the Welsh Government. However, I would not have been party to all of the information in this regard.

36. In Powys, a key issue was venues for mass testing. No testing facilities were initially identified for Powys and at Powys THB we did not agree with this decision. It proved

necessary for us to push hard to get testing capability into Powys through the Welsh Government, via the military liaison officer, in May and June 2020. The outcome was testing sites being set up in Brecon, Builth and Newtown, to the benefit of the local population, from June 2020.

Informal communications

37. I was not (nor am I currently) a member of any WhatsApp groups which include Welsh Ministers, senior advisors or senior civil servants. I am a member of an NHS bodies' Chief Executives' peer group WhatsApp group, but this does not (and did not) include any Welsh Ministers, senior advisors or senior civil servants, with one exception, in that in November 2021 one of the Health Board Chief Executives, Judith Paget, became a senior civil servant. However, the discussions in this WhatsApp group did not relate to the Welsh Government's response to the pandemic.

Public health communications

38. I had no role in the use of public communications and behavioural management in the Welsh Government's response to the pandemic. From my perspective, the daily statements assisted in helping to understand the latest information and impact on people, and at Powys THB we gained value from localising the messaging to Powys. The Health Board's engagement and communication team put in place a dynamic process to ensure that public health messaging was shared promptly with staff, communities and wider stakeholders.

Lessons learned

39. As discussed above, I believe that lessons were learned by the Welsh Government in relation to issues arising for people with neurodevelopmental issues. I also believe that the distribution of Personal Protective Equipment (**"PPE"**) to the social care sector worked well and that the COVID-19 Vaccination Programme effectively evolved and responded to surge planning.

Transcripts of evidence

40. I did not take part in any evidence sessions before the Senedd relating to the Welsh Government's response to the pandemic.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court 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 in its truth.

Carol Shillabeer

Personal Data

Signed: .....

Date: ...4th October 2023.....