IN THE UK COVID-19 PUBLIC INQUIRY
Chair: Rt Hon Baroness Hallett DBE
Module 2B

Witness Name: Stephen Ivor Moore
Hywel Dda University Health Board
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WITNESS STATEMENT OF STEPHEN IVOR MOORE

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1. I am the Chief Executive of Hywel Dda University Local Health Board ("HDUHB"/ "Health Board") and was appointed to this role in January 2015.

2. I am providing this statement for Module 2B of the UK Covid-19 Inquiry and I understand that this module will consider core government political and administrative decision-making within the Welsh Government (referred to within this statement as WG).

Background and Qualifications

3. I am a qualified accountant (1996) and obtained a Masters Degree (MSc) in Health Economics and Health Policy from Birmingham University (2000). More recently (2016) I was made Honorary Professor of Health Practice by the University of Wales Trinity Saint David.

4. I have worked in healthcare for the past 34 years mostly within the NHS.

5. Between 1989 and 2013 I worked in the South West of England reaching Chief Executive level. From 2010 I was Chief Executive of NHS Cornwall and Isles of Scilly PCT and, in 2013, when primary care trusts were closed down I became Area Director for Devon and Cornwall with NHS England.

6. In 2014 I moved into the private sector as Consulting Director for Health and Social Care Policy at ICF International. ICF is a global consulting company that works with, and provides guidance to, both private and public sector clients. This role gave me a

fresh perspective, through an international lens, on the challenges and opportunities for the NHS.

7. I have co-authored a report on 'International Responses to Austerity' commissioned and published by the Health Foundation in September 2014.

8. Since 2015 I have had the great privilege of holding the position of Chief Executive at HDUHB.

Overview and relationship with Welsh Government

9. In Wales healthcare services are primarily delivered by seven Local Health Boards responsible for the health and well-being of its resident population through planning, securing and delivering healthcare services in a specific geographical location.

10. HDUHB plans and provides NHS services for around 384,000 residents across an area of West Wales one quarter of that country's landmass. It is largely a rural area with areas of urban deprivation and therefore its own unique challenges.

11. HDUHB provides hospital care across four main acute hospitals, seven community hospitals and two integrated care centres. The Health Board commissions Primary Care through forty two general practices (alongside six Health Board managed practices), forty one dental practices, ninety seven pharmacies and forty five optometrist practices. In addition the Health Board provides Mental Health and Learning Disability services across a number of locations.

12. The Health Board is responsible for improving physical and mental health outcomes for its population, promoting health and well-being and reducing healthcare inequalities. It does this in partnership with three local authorities and commissions services from other organisations, including the third (voluntary) and private sectors, to achieve these aims.

13. The Health Board is made up of the Chair; the Vice Chair with specific responsibilities for Primary, Community and Mental Health Services; the Chief Executive (the "Accountable Officer"); Executive Directors who are employees of the Health Board; Independent Board Members appointed by the Minister for Health and Social Services

and Associate Members. This group is responsible for the overall governance, control and effectiveness of the systems in place for delivering the Health Board's objectives.

14. As the Chief Executive I am responsible for leading this integrated organisation and reporting to the Chair and Board. A copy of my job description is attached **[SM-001 - INQ000283246]**. My key responsibilities are leading the re-design of the health and care system in West Wales so that hospital based care is on a sustainable footing with the focus shifted to population health management, proactive care and a socially based model of health and well-being.

15. I am also responsible for developing a strong Board, along with the Chair, and executive team, an open and value driven culture across the organisation and improving performance whilst addressing a significant and long standing financial deficit.

16. During the pandemic those core functions remained unchanged but, obviously, there was a change in focus. I became Chair of Gold Command, the organisational structure established in direct response to the pandemic, whilst other roles and responsibilities were suspended. For example, the membership of some national groups and WG performance targets, in particular screening programmes and planned elective care waiting times.

17. Gold Command, the 'Gold Strategic Group', was a strategic response to the pandemic with the first group meeting being held on 13th March 2020 **[SM-002 - INQ000283266]**. At the time of this meeting I was suffering from Covid and therefore attended remotely as an observer with Professor Philip Kloer (Medical Director and Deputy Chief Executive Officer) acting 'Chair'. Following my formal return to work on 23rd March 2020, I became Chair of Gold Command which took responsibility for strategic objectives with overall control of the Health Board's resources in order to achieve those aims whilst considering long term resourcing implications.

18. The Gold Group delegated to the Tactical Silver Group (initially the Coronavirus Tactical Group) which was the essential link between policy aims and the Bronze operational groups.

19. The frequency of Group meetings fluctuated in line with Covid prevalence and demand. For example, the Gold Group initially met on a daily basis but, later in the pandemic, would meet only when a specific decision was required.

20. Prior to the pandemic I, other Health Board executives and the Health Board's Director of Public Health, Ros Jervis now sadly deceased, worked closely with WG over a wide range of issues.

21. I attended regular 'All Wales' Chief Executive Management Team Meetings (CEMT) and NHS Wales Executive Board Meetings, the latter being chaired by Dr Andrew Goodall the Director General of the Department for Health and Social Services/Chief Executive NHS Wales. These were formal, monthly minuted meetings involving WG and the Chief Executives (CEs) of all seven Local Health Boards, the three NHS Trusts and the Special Health Authorities. In November 2021, when Dr Goodall left to become WG's Permanent Secretary, Judith Paget was appointed Director General and chaired these groups.

22. Immediately following the pandemic's onset the March and April 2020 NHS Wales Executive Board meetings were suspended and replaced by more regular 'All Wales' conference calls involving the Director General and all CEs. In March 2020, at the very start of the pandemic, due to my absence from work as I had contracted Covid, Professor Philip Kloer attended these meetings on the Board's behalf.

23. I was, in fact, physically away from work due to Covid from 13th to 23rd March 2020 although I attended meetings remotely as an 'observer' and continued to involve myself in decision making and dealing with relevant correspondence until my return.

24. Through these meetings, which were essentially intelligence sharing forums, I believe we created a good working relationship with WG, with advice being disseminated as it was emerging through regular informal Touchpoint meetings between all CEs and the WG Director General and his senior team. Initially these meetings were held almost daily moving later, as the pandemic progressed, to a weekly basis.

25. The more formal, minuted NHS Wales Executive Board meetings, which in September 2021 became formally known as the NHS Leadership Board meetings, were resumed on 19th May 2020.

26. In addition, and in direct response to Covid, WG through Dr Andrew Goodall established the Planning and Response Group (PRG) along with a sub-group for Acute Secondary Care. These were the WG's designated liaison groups for information sharing purposes throughout the pandemic.

Initial response – January to March 2020

27. I believe I first became officially aware of Covid-19 on 21st January 2020 at a national CE meeting chaired by the WG Director General Andrew Goodall **[SM-003 - INQ000283264]**.

28. On 23rd January 2020 an official update on the spread of Covid-19 in China was provided by Dr Chris Williams, Consultant Epidemiologist, Public Health Wales NHS Trust (PHW) **[SM-004 - INQ000283270]**. I note that this correspondence refers to previous January briefings from PHW relating to the Wuhan outbreak (8th and 10th January 2020) **[SM-004.1 - INQ000283268 and SM004.1.1 - INQ000283269]** although I have no actual recollection of being aware of these at the time.

29. On 24th January 2020 Dr Frank Atherton, Chief Medical Officer, wrote to all Chief Executives regarding NHS Wales' readiness to respond to 'High Consequences Infectious Diseases'. The CEs were asked to provide their 'completed checklists' by 31st January 2020 and these are attached **[SM-005 - INQ000283255 and SM-005.1 - INQ000283237]**.

30. Through February 2020, and in response to a series of WG requests mainly from Dr Atherton, I was involved in surge planning focusing, initially, on the Board's Intensive Therapy Units, bed capacity, PPEs and workforce training in response to the emerging threat.

31. On 19th February 2020 I formally wrote to Dr Frank Atherton, in response to a further WG request, confirming the ability of HDUHB to increase capacity for the management of possible Covid-19 cases requiring hospital admission **[SM-006 - INQ000283250]**.

32. Throughout this period WG made rapid and frequent requests for updates in regard to the Health Board's plans to address, in particular, ventilator capacity, the isolation of patients, details of PPE stock, demand and capacity plans and costs committed in response to the Covid outbreak.

33. In this time, when such requests were frequent and our understanding about the pandemic limited, the Health Boards required and asked, through the Acute Secondary Care sub-group, for greater clarity on what was required. On 24th March 2020, Professor Chris Jones, Deputy Chief Medical Officer **[SM-007 - INQ000283258]** wrote to the Health Boards outlining the priorities for implementation and we responded, largely through the Gold Group, in ensuring, as far as possible, that such measures were in place.

34. I think in the very early stages of Covid-19 there were significant concerns but it was difficult to gauge how serious the threat was going to be. There had previously been outbreaks of SARS and MERS but the spread had, in fact, been limited. Certainly by March 2020, when the modelling data available at the time for surge capacity was being presented, the public health threat was being taken very seriously indeed. This was reflected in the steps then taken to secure adequate bed capacity through Field Hospitals.

35. Of particular concern to the service in West Wales was the potential for a large influx of second home owners and people travelling from outside the region to holiday homes and/or caravan parks. I believe both I and Professor Kloer raised this issue on around 20th March 2020 with WG during CE touchpoint meetings.

36. In respect of WG I believe that they provided advice in a timely fashion their decisions and guidance being driven by the expert advice then available. I was not directly privy to such advice but all organisations, throughout this period, were reliant upon experts whose views were based upon unknown quantities and we could only use the expertise available at the time.

37. I am therefore not critical of the steps and actions taken by the WG.

38. I do not feel 'expert' enough to provide a general opinion on lockdowns and whether or not they were the most appropriate strategy. I can only speak from the Health Board's local experience where, possibly due to the rural nature of the area and, in general, the good community compliance with restrictions, lockdown appeared to be an effective response. One also has to remember that West Wales was geographically sheltered from the initial infection wave, which commenced in the more urban East Wales, and the timing of lockdown appeared to interrupt its spread west.

39. In this period specified decision making in Wales was very much aligned with the UK government although this changed in the later stages of the pandemic. I believe that this alignment in the pandemic's early phase was a reflection of the nascent state of knowledge at the time both in the modelling of data and how different communities might be affected. Certainly the smaller devolved countries (Wales) benefited from the pooled experience and expertise that the UK government provided but the modelling data, particularly for surge capacity, proved to be a significant over estimate as to the bed space we, in fact, required.

40. As for border alignment and international travel there are, of course, many competing issues to consider in such decision making. The one point I would make is that of the first five cases of Covid-19 identified in our region four came from residents returning from abroad via international flights. I was, in fact, one of these four cases having returned from Northern Italy.

Engagement with Welsh Government

41. I believe that I had a good working relationship with WG with regular meetings between CEs and PHW where intelligence and information was shared and where the lines of communication were always open.

42. I had no formal role in WG's core decision making although the information we shared with PHW at these meetings and through the information gathered from our Command Centre informed the WG. For example, on 12th and 13th March 2020, I and the Welsh Medical Directors wrote separately to WG advising upon the suspension of elective care procedures in order to provide capacity for anticipated demand **[SM-008 - INQ000283251 and SM-009 - INQ000283252]**.

43. Similarly I had no formal role in providing specific advice to WG other than providing information and feedback through the regular meetings we held.

44. In terms of my involvement with committees, groups and forums my contact with WG was through the regular CE meetings and the NHS Executive Board meetings which were resumed in May 2020.

45. Following my return to work (23rd March 2020) I also had regular meetings, often weekly information sharing calls, with the local politicians (Members of the Senedd and Members of Parliament), with the Chief Executives and Leaders of the three local authorities within the Health Board's area (Ceredigion, Carmarthenshire and Pembrokeshire) and with the Community Health Council.

46. I did not meet, in any formal capacity, with the First Minister. The Health Minister would often be present at the 'All Wales' CE meeting in order to be kept abreast of developments.

47. The Health Board had regular access to Wales-specific modelling data provided by WG throughout the pandemic. Such data was issued from February 2020 as part of WG's National Advisory Cell which was advising Westminster. This was high level data used for forecasting, in the early stages, the impact of the virus on populations.

48. The collection and passing of data to WG was fundamental to its core decision making. HDUHB had its own internal tools for data collection and submitted daily 'SITREPS' to WG for each hospital site following standard operating procedures issued by WG. This data initially related to critical care capacity and activity but was later extended to include types and numbers of patients discharged and admitted, patient deaths in hospital, numbers of ventilated beds, surge capacity, hospital mortuary capacity, number and type of oxygen devices and on-site oxygen capacity and mental health bed occupancy.

49. From March 2020, Covid-19 cases and deaths were reported to PHW via its 'Notifiable Death' process. Data was validated by teams based within each hospital and submitted daily including weekends.

50. This flow of information and data worked well although there were some initial teething problems when in April 2020 it was discovered that there had been a significant underreporting of notifiable deaths by HDUHB. This was remedied through further staff training in the paramount importance of such data collection.

51. Mostly the systems worked well. HDUHB developed its own internal Modelling Cell, led by Andrew Carruthers, Director of Operations (DOO), for its four hospital sites which was linked closely with the WG's own Modelling Cell enabling the Board to forecast the impact of the pandemic and measures taken upon each of its hospitals.

52. The WG set up and chaired a national group, the Covid 19 Planning and Response Group (PRG), which in the pandemic's initial phase met twice weekly and enabled the Health Boards to directly link up with the Tactical Advisory Cell (TAC) in order to work through the local implications for national modelling.

53. Andrew Carruthers, as DOO, carried out this role on behalf of the Board. We felt that there were close links with the TAC and open discussion with the ability to challenge and clarify the modelling being presented. Whilst we did not consider this to be a formal consultation process there were many discussions on the impact of modelling on operational services and the DOO felt that the WG triangulated data from the different models available.

54. I also found the WG generally receptive to questions concerning data, statistics, scientific advice and modelling. If I, or any of the CEs, during the regular calls with the Director General, had any such questions I believe that they would be referred on to either the TAC and/or Tactical Advisory Group (TAG) as appropriate.

NPIs

55. Through the Public Health Cell Regional Incident Management Team (consisting of the Health Board and the three local authorities), led by the Director of Public Health initially and then by the Director of Therapies and Health Science (Alison Shakeshaft), intelligence relating to community incidence, testing results, hospital demand etc was provided to WG allowing them to make informed decisions on each aspect of NPIs.

56. A specific example would be the provision of local nosocomial infection rates which assisted the WG in making decisions relating to hospital visiting and the use of face coverings within hospitals across Wales.

57. I understand that NPIs were considered across a number of national group structures – Nosocomial Transmission Group (NTG); Infection, Prevention and Control Training Group (IPCTG); All Wales Health Care Associated Infection Delivery Board (HCAIDB); Test, Trace and Protect (TTP); Testing Clinical Advisory and Prioritising Group; Infection Prevention and Control Training Development Task and Finish Group.

58. The NTG was led by representatives from WG, Dr Chris Jones and Professor Jean White, Chief Nursing Officer. I understand that meetings commenced on 19th May 2020 and were, initially, weekly but then varied somewhat in line with the demands of the pandemic.

59. These meetings were attended by officials from WG, PHW and various NHS bodies. Mandy Rayani, Director of Nursing, Quality and Patient Experience, attended in her role supporting PHW in managing infection and antimicrobial resistance. The NTG considered a range of issues relevant to NPIs. For example the use of face masks were a topic for discussion on 6th January 2021 and I attach the minutes of this meeting which Ms Rayani attended **[SM-010 - INQ000283274]**.

60. I understand from Mrs Rayani that the lead on this topic was taken by Dr Eleri Davies (Cardiff & Vale UHB) and Mrs Rayani was concerned with the operational delivery of decisions made rather than the providing of formal advice.

61. To this end, operational delivery, groups were set up internally, such as the Social Distancing Cell, which worked with the relevant teams to ensure compliance, as far as possible, with WG guidance.

62. Mrs Rayani, in her capacity as an Executive Director of Nursing, Quality and Patient Experience (and not as a HB representative) was involved in a number of the groups mentioned. She chaired the IPCTG and the All Wales Infection Delivery Board – groups which also discussed issues such as face coverings and reported to the NTG. As a result of her chairing the All Wales HCAIDB, Mrs Rayani was asked to participate in the NTG.

63. I understand that the TTP group would have been concerned with self-isolation, school closures and their impact on young people and children.

64. Other Groups considering NPIs would have included the already mentioned PRG which discussed the need and timing of 'firebreaks' and associated restrictions with the WG on an ongoing basis.

65. I do recall NPIs being part of the discussions at the NHS Wales Executive Board Meetings normally chaired by the WG Director General. Formal minutes of these

meetings were taken and kept by the WG and any decisions following such meetings were then properly articulated in correspondence between WG and Health Boards.

66. For example, on 20th October 2020 it is clear that 'Nosocomial transmission and outbreak management' was included on the agenda and, whilst I have no independent recollection of the meeting, discussion would have been around the suggested 'guidance' from the WG in the light of everyone's shared experiences to date **[SM-011 - INQ000283263]**.

67. NPIs were also a topic for discussion during the regular informal touchpoint meetings between all Welsh CEs mentioned above. These meetings, which initially took place daily then weekly from 12th May 2020, were 'informal' and, to my knowledge, not minuted. I have no recollection of the detail involved but, from my own brief notes made at the time, I can see that on 24th March 2020 'working from home' was considered; on 11th May 2020 'lockdown' was discussed and on 3rd November 2020 the impact of a 'firebreak' **[SM-012 - INQ000283232, SM-013 - INQ000283231 and SM-014 - INQ000283233]**.

68. I do not believe that we provided the WG with any advice on the identification or consideration of at risk or clinically vulnerable groups save I do recall we provided some clinical expertise, through a local anaesthetist, on the management of those patients vulnerable to developing respiratory complications. This was actioned at a clinical level.

69. Although we established, as an open two way channel with our BAME staff, an internal BAME advisory group, we relied upon PHW for advice and guidance involving specific groups of people.

70. On the whole the moving parts between WG and the Board worked well. We received timely advice and information and, in turn, were able to provide the WG with important emerging data which was then acted upon. I felt that the WG were always receptive to the local intelligence we were able to provide although the speed in which advice changed was a challenge to manage locally.

71. An example of such good co-ordination would be the imposition of the local 'firebreak' lockdown in specific wards of the Llanelli area. Following correspondence from WG **[SM-015 - INQ000283254]** in September 2020 it became apparent that infection rates

in parts of Llanelli were high and a request, through the Regional Incident Management Team, was made to the WG for specific localised interventions to suppress these rates rather than taking measures across the whole of Carmarthenshire **[SM-016 - INQ000283247, SM-016.1 - INQ000283262, SM-016.1.1 - INQ000283261, SM-016.1.2 - INQ000283235 and SM-016.1.3 - INQ000283234]**.

72. On 25th September 2020, under Part 2A of the Public Health (Control of Disease) Act 1984, local restrictions were put in force and the outbreak successfully controlled **[SM-017 - INQ000283267]**.

73. This was effective communication between those arms of the WG (daily monitoring through the Health Protection Oversight subgroup) and the Board (IMT) resulting in positive legislative action.

74. It is also my understanding, from Andrew Carruthers, that through the PRG he was able to express an opinion in relation to the timing and duration of the Christmas 2020 'firebreak' in Wales which commenced on 19th December 2020 and was lifted on 13th March 2021. Concerns raised at these meetings in the latter part of 2020, that local restrictions were neither sufficient or sustainable, are believed to have been taken into account by WG in deciding upon, and then bringing forward the date, for this lockdown. I attach one such example, dated 27th October 2020, provided from Mr Carruthers' contemporaneous notes **[SM-018 - INQ000283228]**.

75. My view is that the WG, throughout the pandemic, gave consideration when considering NPIs to all the relevant groups. Whether that consideration was sufficient is not a judgement I am qualified to make.

Local Lockdowns/Restrictions

76. I believe I have addressed this issue already but would add that I do not consider that the difference between England and Wales led to any local issues for HDUHB.

Care Homes

77. On 13th March 2020 the former Minister for Health and Social Services (Vaughan Gething MS) issued a written statement setting out a 'framework of actions' in order to prepare the health and social care system for the expected surge in Covid-19 cases

[SM-019 - INQ000283278]. This statement was then followed up by a letter from WG (on behalf of Dr Goodall) dated 14th March 2020 **[SM-020 - INQ000283260]** confirming agreement to the framework.

78. This 'framework' within which "local health and social care providers can make decisions" included the following action plans:
    a. *"Expedite discharge of vulnerable patients from acute and community setting"* – Point 4;
    b. *"Fast track placements to care homes by suspending the current protocol which gives the right to a choice of home"* – Point 7

79. The Ministerial statement (and agreed framework set out in Dr Goodall's letter) refers to advice being taken from NHS CE's and Medical Directors which I believe refers to the advice I and others provided to the WG on the suspension of elective services and related matters **[SM-008 - INQ000283251 and SM-009 - INQ000283252]**. I was not asked for, nor did I provide, any specific advice in relation to the testing of asymptomatic patients prior to their discharge into care homes.

80. On 6th April 2020 the WG published specific guidance titled 'Covid-19: Hospital Discharge Service Requirements which followed similar guidance issued by NHS England on 19th March 2020 **[SM-021 - INQ000283229]**.

81. It has to be remembered that in the very early stages of the pandemic there was very little time for consultation and/or considered debate and that the regular meetings between WG and the CEs were, at this juncture, more at the level of information sharing and feedback.

82. Care Homes were discussed, along with many other issues, at meetings between the CEs and the Director General WG. For example, on 10th April 2020 my notes of the meeting on 10th April 2020 **[SM-022 - INQ000283230]** relate to an escalation policy the Board were developing following an outbreak at a local nursing/residential home (Ty Mair Care Home, Llanelli) which demonstrated the difficulty in sustaining care provision when sickness absence and medical suspension impacted on the nursing and healthcare support workforce.

83. That escalation policy was approved by HDUHB's Gold Command on 22nd April 2020 and then shared with WG who highlighted the policy as an exemplar of its kind. The policy was also provided to the other Health Boards.

84. On 21st April 2020 the WG announced the testing of all residents returning to care homes. By letter dated 22nd April 2020 we were informed by the WG Health and Social Services Group that all hospital patients were to be tested before being discharged to care homes through the "Care Home Testing from CMO and Deputy Director General to Health Board CEs, Local Authorities and Registered Providers" **[SM-023 - INQ000283257]**.

85. In late April 2020 I believe that Jill Paterson, Director of Primary Care, Community and Long Term Care was part of the discussion with WG relating to general concerns from within the Care Homes sector (through existing Officer meetings) but neither I nor the Board were formally involved in the decision making – either the decision to not test prior to discharge or the subsequent change in that policy.

86. Whilst consultation may have been the ideal the WG had to act on the information and expert guidance it had at the time and respond quickly to a constantly evolving situation.

87. Having said that these decisions did arrive with little or no notice and, as I have expressed, no formal consultation. There was already an existing group, the Complex Care Leads Group, of which Jill Paterson, as a representative of the Health Board, was a member/director. This Group had considerable experience in service delivery within the Primary Care and Community sector and an understanding of how Care Homes operated.

88. I am aware that Ms Paterson believes that discussion and/or engagement within such a Group prior to the discharge of patients would have been beneficial as there appeared to be a lack of appreciation, at a national level, of the practical implications of their policy making.

89. However we all acknowledge that these judgments are easier to make in hindsight. It should also be borne in mind that at the start of the pandemic the focus was on moving patients out of hospital, where it was thought they were most at risk, and the capacity for Covid testing was being developed.

90. I also recall, and this was an important consideration in not testing patients prior to their discharge, that there was a belief that the testing of asymptomatic patients would be unreliable.

91. From my perspective there were a number of significant decisions made by WG in respect of Care Homes:

    a. 14th March 2020 Rapid Discharge & Care Home Lockdowns Guidance allowing for rapid and safe discharge without needing an MDT meeting and suspending the right to a choice of home **[SM-020 - INQ000283260]**;
    b. 23rd March 2020 guidance restricting visits to care homes issues **[SM-024 - INQ000283259]**;
    c. 6th April 2020 – Health and Social Services Group Guidance on the discharge of all patients from acute hospital settings as soon as it was clinically safe to do so **[SM-021 - INQ000283229]**;
    d. 8th April 2020 PHW Guidance providing advice for residents in Residential Care Settings on care, socially distancing, isolation of symptomatic residents, shielding and exposure of care home staff **[SM-025 - INQ000283271]**;
    e. 22nd April 2020 – Joint letter from WG changing the policy on testing and providing advice and information on the extension of testing and step down care for individuals awaiting transfer but whom have tested positive **[SM-023 - INQ000283257]**;
    f. 2nd May 2020 – WG/ministerial announcement that all care home residents and staff would be tested with subsequent announcements on how to access testing and testing kits **[SM-026 - INQ000283277]**;
    g. 15th and 16th May 2020 – WG TAC guidance, and corresponding Ministerial Statement, on the efficacy of testing in care homes during and following new outbreaks of Covid-19 and, in particular, the value of selective screening and surveillance testing of staff **[SM-027 - INQ000283276]**;
    h. 5th June 2020 – CMO/WG Health and Social Services letter on the weekly testing of all care home staff **[SM-028 - INQ000283248]**;
    i. 17th December 2020 – Department of Health and Social Services to Chief Executives and Directors of Social Services on Patient Discharge: Choice of Accommodation setting out principles to be applied in discharge from hospital **[SM-029 - INQ000283249]**;

j. 9th March 2021 – WG published its Framework for Covid-19 testing in hospitals prior to discharge to care homes or other health or social care facilities **[SM-030 - INQ000283280]**;

k. 24th March 2021 – Deputy Minister for Health and Social Services provided an 'action plan' for care homes focusing on key areas including infection control, PPE, well-being of residents and staff and financial sustainability **[SM-031 final March 2023 version - INQ000283272]**;

l. 17th December 2021 – letter issued by WG updating guidance on the entry criteria for professionals visiting care homes **[SM-032 - INQ000283256]**.

92. I do not believe I, nor the Board, were formally consulted prior to these core decisions being taken. I believe such decisions were taken by WG in the light of the developing expert advice available to them and in response to the intelligence and information being fed back from all of the Boards through ongoing active discussion at the various group levels alluded to in this statement.

93. Ideally, and it would be the norm, a longer and more formal consultation process prior to such decision making would allow time to consider and reflect on unintended consequences.

94. Time was however at a premium and Health Boards primarily needed advice and direction. Subject to the points I have raised I do not feel that further consultation was required. The WG needed to act decisively with the information it held and the 'consultation' process that existed was, in my view, proportionate to the situation we faced.

Impact on Hospitals

95. In this part of my statement I will focus on the core decisions taken by WG where I consider there was a measure of 'consultation' or where there should have been. As a general point I would repeat, particularly in the early phase of the pandemic, speed of guidance was more important than a potentially lengthy discussion process.

Discharging of Patients

96. "The prioritisation of non-emergency transport service to focus on hospital discharge and ambulance emergency response" and "Expediting the discharge of vulnerable

patients from acute and community hospitals" **[14th March 2020 SM-020 - INQ000283260]**. Whilst I do not believe that this was the result of any formal consultation process it was the WG acting in response to the seven Health Boards' suspension of elective services and an acknowledgement of the clinical experience of managing patients at the time.

97. "The introduction of testing for residents returning to care homes" [21st April 2020]. As I have explained there was no formal consultation process but the decision to test patients being discharged into Care Homes is likely to have been influenced by the direct feedback from members of Health Boards across Wales concerned by the problems being experienced in this sector.

Hospital Capacity

98. "The suspension of non-urgent outpatient appointments and surgical admissions and procedures (framework of actions announced by the Minister for Health and Social Services)" **[13th March 2020 SM-019 - INQ000283278]**. This decision was the result of the concerns expressed by all CEs (and Medical Directors) of the Health Boards about the need for adequate staff and facilities required for the projected critical and enhanced respiratory care.

99. "Ministerial statement re numbers required for critical care/invasively ventilated beds with an additional 1,035 ventilators being procured by NWSSP" **[6th April 2020 SM-033 - INQ000283273]**. I recall this issue being raised during a number of CE/DG conference call meetings in March and April 2020 and this decision would have been based, in part, on the planning assumptions for ICU and beds which we provided to WG.

100. "New service or speciality based triage and streaming processes in both unscheduled and planned care to support the separation of flows - NHS Wales Operating Framework **[5th May 2020 SM-034 - INQ000283265]**. Although I have no formal record of any consultation process, this framework for patient management would have been the product of all learning to date – the CE calls in conjunction with the numerous group contact points between WG and the Health Boards.

101. "Covid Capacity Planning" – letter from Dr Andrew Goodall to all CEs including capacity required in the event of a second peak **[24th June 2020 SM-035 - INQ000283253]**.

This was a synthesis of interpreting the national modelling data and translating that into the local position. Again, whilst we did not give any definitive advice, asking us to provide a local view on the data and modelling was a form of consultation and was undoubtedly considered in Dr Goodall's planning letter.

102. "Minister for Health and Social Services sets out operational status of field hospitals in Wales for remainder of 2020/2021" **[29th September 2020 SM-036 - INQ000283279]**. This would have been based on the experience gained during the pandemic and, in particular, the data and intelligence provided by all of the Health Boards to date.

103. "Health Minister for Wales announces £100m investment to aid recovery from the pandemic, improve services, capacity and cut waiting times" **[20th May 2021 SM-037 - INQ000283275]**. Whilst I cannot recall a specific 'consultation' I would have been present, and involved, in the CEs/WG/ministerial meetings where these issues were discussed.

DNAR Orders

104. I have no particular comments to make in respect of DNAR Orders save that our existing approach to such directives did not change during Covid and each case would have been considered on the criteria established prior to the pandemic.

Test, Trace, Protect

105. The WG/PHW set up the TTP Programme Board to provide the strategic oversight for TTP in Wales. The Board met weekly, I believe it was chaired by Jo-Anne Davies (WG Education and Public Services) and contained a number of officials from WG and PHW and various NHS bodies. Alison Shakeshaft, Director of Therapies and Health Science, between July 2020 and January 2021, attended on behalf of the Board and, in fact, at the time, was one of only two representatives from NHS Wales.

106. Below this structure were a number of national sub-groups including the TTP Oversight Group and the Testing Strategy Subgroup all of which fed back to the Programme Board.

107. Whilst I was not directly involved in the TTP interface with WG/PHW, I understand that Alison Shakeshaft did raise some concerns with WG, in particular on the efficacy and

practicality of lateral flow testing and the use of LumiraDx testing kits in the early part of 2021, and had a mixed experience in her dealings with WG/PHW.

108. Whilst there were regular meetings she did not always believe operational perspectives were being listened to and sometimes felt that there was contrary advice being sent by the UK government, who on occasions, provided an additional and unhelpful layer. Having said that I understand that she did find working with the NHS Wales Delivery Unit, the government agency designed to provide professional support for performance/service delivery, generally helpful and constructive in relation to the TTP programme.

109. I can recall from my interactions with Alison, both informally and at internal meetings that she was, at times, expressing frustration with the changing nature and deliverability of some WG requirements. I believe that these frustrations were largely as a result of the speed of developments in testing capabilities and approaches and her desire (shared by us all) to ensure that we were providing the clearest support and advice to our staff, patients and local population. I would also note that WG itself was grappling with the deployment of new and evolving testing techniques and having to balance the needs of different sectors and organisations.

110. At a regional level the Health Board was responsible for coordinating test and trace across the three Local Authority areas and provided the necessary financial support. The Local Authorities carried out the day to day contact tracing with the Health Board's Director of Public Health overseeing outbreaks within the community and the Health Board managing outbreaks and protections in hospital settings.

111. Internally a Testing Cell was set up and chaired by Alison Shakeshaft and this group would have reported, on a regular basis throughout the pandemic, to the Health Board Tactical Silver Group.

Informal Communications

112. I was not, nor have been, a member of any WhatsApp or messaging group with Welsh Ministers, senior advisors and/or senior civil servants concerning the Welsh Government's response to the pandemic.

113. There is a social WhatsApp group for the Health Board CEs that pre-dated the Covid-19 pandemic and was created for purely social reasons and would not, I believe, contain information relevant to the Inquiry.

114. Over the period in time I would have exchanged, on an ad hoc basis, some informal text messaging with Dr Goodall. I believe that these messages were largely confined to issues relating to the reporting of my illness and Covid related deaths during the pandemic.

Public Health Communications

115. The WG's public health communications to HDUHB were clear and I consider that there was good linkage between the Health Board and WG and then dissemination within our region. A key part of my role, and that of the Chair, was to keep staff, Local Authorities, constituencies and politicians fully updated.

116. We used a variety of channels to convey WG's public health information and guidance both to members of the public and Health Board staff.

117. Professor Philip Kloer, initially, and then I, provided weekly briefings on these issues to local members of the Senedd and MPs, held weekly Community Health Council Managing Director and Chair briefings and similar briefings with Local Authority CEs and Leaders. The frequency of these changed in response to changing pandemic conditions. We also used a variety of electronic messaging to keep these groups informed.

118. These briefings enabled, in particular, politicians to keep the public informed and reassured and to ask questions on behalf of their constituents.

119. We created a staff only Facebook page and provided regular internal staff bulletins including video logs from me and other members of the Board.

120. We issued guidance directly to the local public through publications and media channels including at least one BBC interview.

121. I also held, along with the Board's Chair, fortnightly informal Board Independent Member meetings to catch up on current news and developments.

122. Again generally I believe that public health communications worked well and, in my view, there were no obvious missed opportunities although, particularly early in the pandemic, there were mixed messages on the value of wearing face masks and I think this was confusing for the public.

Lessons Learned

123. The WG's approach over the course of the pandemic evolved in line with learning and reflected knowledge over time as to how the virus spread, rates of hospitalisation and death rates.

124. This evolved learning, in relation to decisions taken by WG (and devolved decisions by the Health Boards), would probably, in my view, have led to some decisions being taken earlier, such as imposition of lockdowns and use of PPEs, and some decisions being taken rather differently.

125. The latter point is illustrated by the establishment of Field Hospitals which were set up and operationalised in response to modelling data available on required 'surge capacity' at the time.

126. The early modelling data did not take sufficient account of unenforced public behaviour changes prior to lockdown and, although Field Hospitals were rapidly mobilised in partnership with the Local Authorities and at considerable expense, provision turned out to be well in excess of demand. We were, however, able to use, in part, such hospitals for step down care.

127. I believe that a better response, and more efficient use of resources, would have been the provision of fewer, larger regional Field Hospitals at an 'All Wales' level with all Health Boards contributing. The role of these hospitals could have been more considered had they been part of national pandemic preparedness prior to the outbreak recognising the need to address various possible scenarios depending on the course the pandemic actually took.

128. Also, if we had known that there would be a national lockdown, different decisions may have been taken in relation to Field Hospitals notably their configuration and capacity requirements.

129. In relation to PPEs whilst there were, of course, issues regarding the global supply chain, I believe that the existing PPE stock held in Wales immediately prior to the pandemic was out of date and inadequate and this contributed to the problems with sourcing and supply.

130. However through both local and national efforts these challenges were over quite quickly and the Shared Service Model in Wales was a considerable strength in coordinating procurement at a national level.

131. There are many positives that HDUHB have taken from this experience in supporting the WG's response to the pandemic. The institution of the Gold Command Group with the clarity it provided to decision making resulted in an overhaul of the Health Board's governance structure. This revised structure (the Board Assurance Framework) has provided an enhanced model for performance management and the principles of Gold Command have become embedded in a central communications hub – an efficient 'single point of contact' model **[SM-038 - INQ000283245, SM-039 - INQ000283236 and SM-040 - INQ000283238]**.

132. In support of decision making at Health Board level, HDUHB also set up an Ethics Panel which provided invaluable guidance throughout the pandemic. This Panel, unique at the time, has endured and continues to provide important help and assistance to the organisation.

133. I also believe that Wales benefited from effective and close connections between front line managers and officials within central government and this was facilitated by being a relatively small country with close professional links.

134. Whilst many of these working partnerships were in place prior to the pandemic they have been considerably strengthened by the challenges of Covid-19.

135. What would improve the response to a future pandemic?

136. In my view clarity on the types and use of PPE and maintenance of stock.

137. A national policy on the provision of pandemic 'Field Hospitals', their use, location and staffing and how they are to be funded.

138. I, along with the Chair and Director of Operations, have already provided evidence on the response to Covid-19 to the Senedd (Health and Social Care and Sport Committee) on 10th July 2020 and 24th February 2021 **[SM-041 - INQ000283243 and SM-042 - INQ000283244 respective transcripts and written evidence provided in advance 3rd July 2020 SM-041.1 - INQ000283239 and 16th February 2021 SM - 042.1 - INQ000283241]**.

139. The Health Board also submitted written evidence to the Health and Social Care Committee in respect of the health and social care workforce on 8th October 2021 and that same committee on the impact of waiting times backlog and effectiveness of the WG's Health and Social Care Plan 2021/2 on 20th January 2022 **[SM-043 - INQ000283240 and SM-044 - INQ000283242]**.

140. In conclusion, I am very proud of the Executive and wider team at Hywel Dda University Health Board in how they led Wales in response to the pandemic. There are always things that could have been done better, but I believe that decisions were a product of the information available at the time and the unique circumstances we faced.

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 in its truth.

Signature: **Personal Data**

Name: **...Stephen Ivor Moore.....**

Dated: **...11th October 2023.....**