Witness Statement: Sharon Hopkins, Former Interim Chief Executive Officer, Cwm Taf Morgannwg University Heath Board (CTMUHB)

Module: 2B of the UK Covid-19 Public Inquiry

Subject: Request for Evidence under Rule 9 of the Inquiry Rules 2006 Reference for Request: M2B/LHB/SH/01

Introduction

1. For all of us, myself and Cwm Taf Morgannwg University Health Board ('CTMUHB'), the COVID19 Pandemic ('COVID19') was unprecedented and in my view the Health Board's response during my time as Interim Chief Executive from January-August 2020, was remarkable. I would like to pay tribute to all the staff who worked tirelessly to support the care and treatment of CTMUHB's patients and communities during what was an extremely difficult, challenging and ever-changing environment. There is learning for us all about how our preparation, response and recovery could have been done differently and potentially our outcomes improved but nonetheless I am proud of the organisation's response.

2. For the purposes of this statement, I have focused upon the period of time from 21 January 2020 up until my retirement on 31 August 2020. Since retiring in August 2020, I no longer have access to any former work-related WhatsApp Groups, nor have I retained any notebooks or diaries from this time. I understand that my CTMUHB email mailbox was archived following my retirement and therefore it has been challenging to review the exact dates and frequency of meetings during this time, however, I have reflected on these with the information available and to the best of my recollection within this statement.

3. Looking back on my experience through the emergence and first wave of COVID 19 in Wales from January 2020 to August 2020, there are five reflections which I have included at the end of my statement, for consideration by the Chair, which I do hope will be of use.

4. In preparing this statement, I have reviewed copies of documents kindly supplied by to me by CTMUHB. My independent recollection of the content of these documents is variable. Although these events took place relatively recently, I have not been involved in the NHS for over three years now and at the time in question the pace was frenetic, not only trying to

manage what we knew but also navigating a situation entirely outwith our experience. I have found it challenging to remember exactly what was discussed on what date and with whom. On some of the issues raised, for example when I provided evidence to the Health, Social Care and Sport Committee Fifth Senedd on 10 July 2020, I have only a limited recollection of the specifics and am reliant on the documentation.

5. I have endeavoured to answer the Inquiry's questions as fully as I am able against these limitations. If required, I will revise my statement in light of any further material which is brought to my attention.

Background & Qualifications

6. I qualified as a medical doctor, MB; BcH; BAO; BA, from Trinity College Dublin, Ireland in 1984. Following completion of junior doctor training posts I undertook a Fellowship at the Wilmer Eye Institute, Johns Hopkins, Baltimore, USA from 1988 to 1990. I went on to become a specialist in Public Health Medicine, training in Cambridge and Cardiff and gaining my membership of the Faculty of Public Health Medicine UK in 1993. I was appointed as a Consultant in Public Health Medicine in 1994 to Bro Taf Health Authority Cardiff, Wales and was appointed to my first Executive Director of Public Health post in 1997. I subsequently held a number of Executive Director posts in Public Health in NHS Wales organisations, at times combined with other executive roles such as Strategy; Innovation; Commissioning; Primary Care and Mental Health and Deputy Chief Executive Officer. I was appointed to Commissioner/Non-Executive Director with the Commission for Health Improvement from 2003-2008 and chaired the Public Health Advisory Committee F at the National Institute for Health and Care Excellence from 2015 to 2019. Alongside my executive roles, I held two Interim Chief Executive Officer ('CEO') posts within NHS Wales towards the end of my career. I was awarded an MBE in 2017 for services to the health and wellbeing of people in Wales and the UK. I have been fully retired since 31 August 2020.

Appointment to CTMUHB

7. I was appointed as Interim Chief Executive for CTMUHB on 24 June 2019, a role which discharges the accountable officer duties for the organisation. I held this role until my retirement on 31 August 2020. As Interim CEO of CTMUHB I was responsible for issues of

accountability, regularity, propriety and annual accounting exercises, and held a senior leadership role for the organisation which provided health services including preventative, community, primary, secondary, mental health and some tertiary care, to a population of about 450,000 people. I was recruited to refocus the organisation, renew and motivate the executive team, engage staff and communities, set new values and strategy, overhaul governance, design and introduce a new operating model, and to begin to restore the reputation of the organisation. At the time, the organisation was in 'Special Measures' concerning 4 areas which provided my focus. A number of other areas demanded attention most notably Brexit preparatory demands, future workforce planning and financial resources. The COVID19 pandemic necessarily altered the focus of my leadership role particularly from March 2020, so that everything I did was against the background of a new infectious disease threat, requiring us to try to understand the behaviour of COVID19, prepare for an unknown impact and to respond as best we could given that we were dealing with an exceptional situation. However, the basic running of health services and all of the previous priorities had to continue to be developed and progressed, albeit at a different level of intensity, and 'regular provision' continually changed as the pandemic evolved.

8. The way in which I led and managed the organisation changed from early March with as many activities as possible being conducted remotely. This increased as the months progressed, and our digital capabilities improved. I introduced an emergency response structure to enable rapid, clear and effective discussion, decision-making and action. During our acute emergency response, from the beginning of March 2020, many of our routine business mechanisms were suspended. I closed our acute emergency response on 21 May 2020 *(SH/1 / INQ00028322 plus a total of 12 Appendices INQ000283210 – INQ000283221)* and reverted the organisation to a necessarily amended version of our previous structure. Suspended services were gradually revised and re-introduced but by the time I retired at the end of August 2020 many were not operating at pre-COVID19 levels. From May 2020, following the first acute COVID19 wave, much of our business continued to be heavily dominated by planning for the expected next wave of COVID19, including further rapid service suspension if necessary. Our planning endeavoured to be informed by the lessons we were learning from the first COVID19 wave and the knowledge we were gleaning by working through all of the sequelae of its immense impact on our health services.

For completeness, the 12 appendices referred to are:
INQ000283210
INQ000283211
INQ000283212
INQ000283213
INQ000283214
INQ000283215
INQ000283216
INQ000283217
INQ000283218
INQ000283219
INQ000283220
INQ000283221

Working with the Welsh Government

9. In my role as interim CEO, I worked very closely with Welsh Government officials, usually through its NHS Executive. I had scheduled, regular meetings with Welsh Government officials as well as ad-hoc discussion as necessary in relation to the particular circumstances of CTMUHB. In addition, I attended a regular monthly schedule of business meetings with Welsh Government officials collectively along with the CEOs of all the health organisations in Wales. The monthly collective meeting with Welsh Government officials and the collective CEOs enabled wider national (both UK-wide and Wales-wide) issues to be debated and discussed.

10. The rhythm of business with Welsh Government officials changed from the beginning of March 2020, with COVID19 becoming the main focus for us all. Contact increased collectively as NHS boards across Wales worked together with Welsh Government officials. On 3 March 2020 the then Director General of the NHS spoke personally to each individual NHS CEO, including myself, concerning the potential very serious impact that COVID19 might have in Wales and on 5 March 2020 he issued a letter *(SH/2 /INQ000283223)* to us, as NHS CEOs, outlining the discussions and plans going forward. I cannot recall the exact timetabling of contact but the collective meetings between Welsh Government officials and NHS CEOs moved from being held monthly to weekly to daily and even more frequently in order to enable prompt information exchange, robust discussion and decision-making to take place rapidly. I recall this as a very intense time where we were all dealing with something entirely new, with very limited scientific knowledge to guide us, and limited understanding of modes of transmission, infectivity, management, treatment and likely impacts on our population of COVID19.

11. I would describe the relationship with Welsh Government officials and my fellow NHS organisations as good, open and supportive. Communication between us all, as NHS CEOs and senior Welsh Government officials, was available 24 hours a day, 7 days a week. Most of our communication was through telephone, Skype, Zoom, Microsoft Teams and email. Methods evolved with the majority of communication eventually being through Microsoft teams. I also introduced regular briefing meetings, usually held weekly, with local leaders in CTMUHB which included local Members of the Senedd and Members of Parliament. I recall that as CEOs we had a social WhatsApp group but as far as I can recall during my time as

Interim CEO this was not utilised for formal business. I left this group following my retirement in August 2020 and no longer have access to these messages. I did not have WhatsApp communication with Welsh Government officials as far as I can recall.

Emergency of COVID19

12. COVID as a serious global concern was highlighted to my organisation with publication of the World Health Organisation (WHO) situation report on 21 January 2020 and became a clear local concern for us, with the first detected UK case at the end of January 2020. Public Health Wales ('PHW') was engaged in debate about COVID19 and public health preparations for Wales from an early stage in January 2020. PHW linked with CTMUHB through our Executive Director of Public Health from about late January 2020. There was a formal Chief Medical Officer (CMO) public health link sent out for the attention of a wide number of leaders including the NHS Wales CEOs on 24 January 2020, which alerted us to the potential for infected travellers arriving from China and indicated steps to be taken which immediately prompted our public health staff to begin our preparations. Subsequent CMO alerts broadened the numbers of countries from which incoming travellers could be at risk of carrying COVID19. Advice for responding to the virus continued to be updated by the CMO and used by us. Early planning and deliberations were based on knowledge of SARS gained from the February 2003 outbreak originating in Asia, in our work and that of PHW.

13. PHW introduced a health and social services COVID19 planning and response group at the end of January 2020 on which CTMUHB had representation. By early February 2020 our local public health tactical COVID19 group was in place and charged with planning and running our public health response in CTMUHB working closely with our Local South Wales Resilience Forum.

14. During February and March 2020, I recall that our attention was on the public health response to a potential infectious disease outbreak of the newly identified COVID19 virus. This included case detection and how to isolate people safely, who may have contracted an infectious disease. We were concerned with how to test potentially infected people safely, and to avoid those administering tests becoming infected, which included the use of personal protective equipment for those attending to potentially infected people. At this early stage our public health response drew on the principles of dealing with highly infectious, potentially unknown

diseases, which is an element of communicable disease prevention, control and treatment practice, albeit most usually for small numbers of cases.

15. As I have previously said we had no experience of an infectious disease pandemic of the type and scale that COVID19 eventually presented. Guidance based on best public health practice, from late February 2020 as I recall, was developed on case detection, symptoms of COVID19 as they were emerging, testing for those suspected of contracting COVID19, investigation of patients with COVID19, how primary care should respond in the face of a potential patient with COVID19. I have to stress that my recall is that up until early March we used public health principles to guide our local and Wales response which in my view was the correct approach. From mid February guidance evolved very rapidly as information emerged on cases in the UK and Europe in particular. For example, the number of people being infected was increasing at a greater rate than we had experience of, mode of infection was unclear, and symptomatology was varied.

16. Preparation for the treatment of COVID19 cases, in identified special units, was being worked upon for us, as I recall led through PHW and the office of the CMO, working with communicable disease clinicians and out local clinical experts. However, in February 2020 potential case numbers we might expect and plan for were influenced by the 2003 SARS experience, these were small numbers. As the international experience developed our concern about likely numbers grew. We had discussion with our clinical staff about preparations for potentially larger numbers of COVID 19 cases in the later half of February 2020, with much debate about routine services being suspended to allow preparation.

Public Health Guidance

17. I recall that public health guidance continued to be issued from PHW throughout the pandemic, this was helpful to us. Discussion in the early months, on guidance and its development, largely took place through our Directors of Public Health. Clinical guidance was issued through the CMO utilising our local, Medical Directors, Directors of Nursing and Directors of Therapies. Discussion around the implications of this guidance occurred in tandem between the CEOs and Welsh Government officials. I recall that we had a desire to try to maintain a common approach on guidance, particularly clinical guidance, across Wales and across the four UK countries but this did lead to considerable delay at times.

18. In Wales public health resources had been diminished over time and subjected to reorganisation, however, although public health was led through PHW, it had a very close relationship with health organisations, including Health Boards. I had an Executive Director of Public Health on my team who was able to take the lead on preparing and operating our public health response and worked closely with relevant Welsh Government Officials. However, by mid to late February it was becoming clear that the infectivity of COVID19, and the severity of the illness would likely impact our health services should experiences in other countries be mirrored in the UK.

19. In February 2020 our key local clinical services concerns regarding COVID19 were our ability to investigate and treat people safely and manage severe respiratory symptoms requiring hospitalisation and even intensive care. We were concerned about caring for those with COVID19 whilst keeping our staff safe. Our capacity to do all of this required a major redesign in how we logistically and operationally ran our services, our care and our clinical pathways for our patients. It was a huge task to be undertaken by our staff whilst they continued to care for our patients in the face of an overwhelming new disease challenge. This required change was reflected in clinical and public health guidance from the Welsh Government and PHW.

20. Although I was aware of UK SAGE meetings, the urgency required for UK national preparation at this time was not apparent to me and there was a frustrating lack of action from UK central government in my view, with the messaging being 'business as usual'. In my view the Welsh Government had a better appreciation of the potential seriousness of COVID than the Westminster-based Cabinet.

21. In my opinion at a UK level the initial lockdown in March 2020 could have been initiated earlier and from a public health perspective was a very necessary action. I cannot comment on the length of the lockdown as I had retired by the end of August 2020.

22. Given that the UK is an island, in my view, potential opportunities that could have been gained by restricting international travel earlier were potentially squandered by the UK government.

23. The public health system in Wales, in my opinion was and is much stronger than that of England, but our national emergency plans for large scale infectious disease outbreaks were weak and not been developed to deal with an infectious disease pandemic beyond flu. The

focus on Brexit planning had also directed manpower away from regular business and developmental work on planning.

24. Public communications from the Welsh Government and its officials during the pandemic I recollect as being regular and informative. My communications team worked closely with that of Welsh Government so that as far as possible messages were localised, followed through locally and messaging was kept coherent.

25. Welsh Government officials were open to local concerns on preparation, but it seemed to me, that many issues were considered UK-wide decisions. It appeared to me that the Welsh Government was not party to some early and subsequent discussions at the UK level in Westminster, which often meant we received information late, almost as the media announced issues and time we potentially could have had to discuss and plan our response then wasn't available. For example, the data modelling on potential numbers of cases we could expect in a best, reasonable, and worst-case scenario was only seen and discussed with Welsh Health Board Chief Executive Officers on 9 March 2020. In my experience once Welsh Government officials had information this was quickly relayed and discussed with us as CEOS in the Health Boards. As the threat of COVID 19 became an inevitability, it seemed to me that Welsh Government officials were very prepared to take action, albeit against a poor UK government communication background. The level of consideration of evidence, listening to experts, keeping the population at the heart of decision-making was very evident to me in discussion with Welsh Government officials and their decision making.

26. Maybe the Welsh Government could have acted more quickly had it not respected the perceived need to act on a UK basis, for example with lockdown, international travel and border control, however these are complex issues.

27. In giving opinion I am concerned that hindsight overlooks the actual situation we found ourselves in at the time. We faced a novel virus, with limited evidence on mode of transmission, infectivity, morbidity and mortality. We had limited evidence on treatment of symptoms and, in the early stages, no vaccines or definitive treatment to work with. We had a deficient pandemic plan. I have no doubt that with a strong and well-rehearsed pandemic plan many of the issues which we had to deal with 'de novo' could have been more rapidly dealt with and in a way which minimised risk and unintended consequences from the outset.

For example, a plan for vulnerable people, a plan for closed settings, and a plan for decisions on utilising scarce resource all could have helped to inform our initial response. In reflecting on actions at a national UK level perhaps the 'island mentality' was an influencing factor in delaying decision making, but with a more scientifically astute approach the very fact of being an island could have been utilised to potentially greater benefit of our population.

28. With the benefit of hindsight, the early phase of track and trace and isolation should have been a very serious priority, and not stood down so early and a greater precautionary approach to mode of transmission could have been taken so that aerosol spread could have better influenced decision-making. These I consider national UK issues as much as issues for a devolved government. As time went on the Welsh Government enabled more local decisions regardless of the UK Government pace and stance.

29. As mentioned above, in early March 2020, as with many of the Health Boards, my Health Board took a decision to set up an emergency response structure given how much had to be done in a very short time, and this was supported by the Welsh Government. This laid out clearly the many issues which we needed to address in the immediate short term and enabled rapid change as necessary. I had the first sight of numbers modelling that was being worked on at a UK level and its application to Wales and my local area on 9 March 2020. The numbers were startling and Welsh Government officials rapidly instructed work on how we would deal with this. Work on large scale workforce plans, capacity planning, patient flows, and communication then had to be delivered and implemented at pace and this became our local emergency response plan which was formally launched on 13 March 2020.

30. The Welsh Government/CEOs group, of which I was a member, was used to steer a common and rapid response across Wales, collectively sharing issues as they arose, risks, potential forward preparation and agreeing solutions, acquiring advice, questioning, so that as much as possible could be completed once for use by us all. In my view this group was an effective mechanism for communication, debate, influencing, understanding and agreement to action decisions. My role in decision-making with Welsh Government officials during COVID 19 was conducted through this group. I recall advice and guidance preparation being prepared by specific tasked groups with whom we worked or had representation.

31. Guidance, prepared by the Welsh Government and PHW sought to help and support our staff in caring for people and our staff worked tirelessly to design and implement change after change. Welsh Government officials facilitated changes by minimising bureaucracy and enabling light touch governance which locally we ran through our emergency response structure and into our Health Board and its sub committees, which were predominantly operated remotely during this time.

32. So many issues were debated and put into place in early March, for example the stand- down of our routine services was discussed collectively with Health Board CEOs and Welsh Government officials in early March and agreement reached with an announcement on 13 March 2020. The discussions we had were thoughtful, and always concerned about risk, consequences and how these might be managed. Communication with the public and with staff was a constant thread utilising local websites and media including social media locally. I recall that Welsh Government officials supported the Health Boards working together collaboratively and we sought reciprocity arrangements between our organisations to enable PPE, equipment and medication to be made available where it was needed most, wherever possible.

Data Collection

33. Our data collection systems were poor, often relying on manual data collection, making surveillance and all the later data requirements to inform our response to COVID a real problem. There were many data sets routinely provided by us to the Welsh Government covering the full range of health and preventative services including quality, performance and resource utilisation. But COVID19 required a different data set, the requirements from the Welsh Government were generally clear with precise reporting deadlines and feedback. Data requirements understandably and necessarily continued to change over the pandemic emergence and first wave which did cause many challenges. We were not a mature digital organisation prior to the pandemic, and this greatly hampered our data collection and information management. This developed at a pace, facilitated by the Welsh Government, but by the end of the first wave of Covid 19 there was still a long way to go.

34. We at CTMUHB had limited resources in terms of skilled personnel and adequate technology to readily collect data, undertake expert data modelling, analysis and interpretation. However,

I was fortunate to have an expert data modeller and analyst in my team who enabled a bespoke service for our Health Board and whose expertise was also lent to the Welsh Government. My recollection is that the Welsh Government shared information as soon as it was available to them.

Non-Pharmaceutical Interventions

35. I recall discussion on non-pharmaceutical interventions (NPIs) with Welsh Government officials in early March 2020 in our Welsh Government/CEO group. In particular, those NPIs that could benefit from a local view or interpretation were discussed in detail so as to enable common response, introduction, communication, and to plan for consequences. For some we had local flexibility, for example working from home arrangements as these in part depended on our IT infrastructure and the service being provided. Social distancing quickly challenged physical capacity for service provision and required significant service redesign for us. I recollect that it impacted on issues such as our ability to safely accommodate patient visitors, accompanying patients, how patients could see clinicians and other caregivers safely.

36. The required need for social distancing measures and minimising person-to-person contact highlighted our poor information technology infrastructure, so that many of our processes still required people to physically undertake tasks, meaning they had to be in our buildings, talking to and interacting with other staff. Safe physical contact requirements highlighted potential problems with access to personal protective equipment, its use often meant having to change the way in which care was provided and, in many areas, the very necessary use of PPE had an impact on our staff, for example in putting PPE on and off takes additional time, learning to work with PPE takes time and practice and use of PPE can be very uncomfortable for staff. These necessary measures brought us concerns about how we provided for and cared for vulnerable people, patients and staff.

37. At the early stages of the pandemic the decisions we were making had to be implemented very rapidly and often with the knowledge that further detail on specifics would be necessary. For example, as risks were identified, specific issues for specific groups became apparent or similarly issues that had been raised but simply couldn't be worked through in detail in the initial response. We were very aware that many of the issues we were discussing would benefit from quality impact assessments. These were a routine tool we employed in our

organisation to enable us to understand any impact on those with protected characteristics, impact on quality, on inequality and indeed impacts that might not be immediately apparent. We used these to inform our decision making, to minimise or avoid unwanted or unintended consequences of change. As the pandemic progressed and the immediate emergency response evolved, more time and attention were available for this work. I have to say though for me the consequences of our service decisions and the impact of provision of service to our communities were a priority.

38. I do recall some specific discussions between CTMUHB and the Welsh Government regarding our COVID 19 infection rates. Our information and data analysis demonstrated that rates of COVID infection in the different parts of CTMUHB reflected our deprivation profile, however, this was not entirely mirrored in other areas across Wales with a similar profile. This was discussed with Welsh Government officials and PHW on a number of occasions in order to explore potential mitigations. I think in about July 2020, the importance of closed environments outwith health and social care impacted us, with an outbreak in a local meat factory and further outbreaks in other factories within Wales. Closed environments are those where people are housed or work in close proximity for long periods of time so that should one person contract an infectious disease it can be more rapidly spread than in other environments. Closed environments in health and social care were known to us, for example hospital wards and care homes, hence our routine use of infection prevention and control teams. The Welsh Government were supportive of us, in enabling discussion and actions, linking across Wales to other similar institutions to try to mitigate any potential outbreaks. Living conditions for groups associated with some of the industries for example meat industry and houses of multiple occupation, that continued to provide services was another area of intense work, across a number of sectors and was again facilitated by the Welsh Government.

39. In my opinion the Welsh Government worked well with us. There were times of frustration with limited data and information, delays in guidance and I have no doubt they similarly found frustrations with us.

Caring for people with COVID19

40. Early preparation for being able to care for the potential numbers of people with COVID19 that the modelling numbers were predicting, was a serious challenge for us. The sickest patients

would require care in our hospitals, for example needing access to intensive care facilities, high flow oxygen, complex medications, expert clinicians, which meant being able to ensure those who could be cared for elsewhere did not reach hospital or if in hospital could be moved to their home or other care environment. Our early protocols were all about identifying people with COVID19 from their symptomatology, isolating and then treating them safely. People presenting to our hospitals with symptoms of COVID19 or those acquiring symptoms whilst in hospital were tested.

41. As March progressed, I recall that the role of asymptomatic people in the spread of COVID19 was becoming a clearer risk. It is important to note that up to this point our testing, and indeed testing UK wide, was for symptomatic people only. Patients with known COVID19 were not discharged from hospital at any point as far as I recall. It was the emerging concern about the role of asymptomatic patients in the infectivity of COVID19 that led to our very serious concerns about how we could safely manage closed environments for our patients and communities (for example care homes, hospital wards) and led to changes in our clinical and testing protocols. This was another example of rapid changes being implemented as new information came to light in a pandemic that we had no previous experience of.

42. I do not have any specific recall of active decision making by the Welsh Government to discharge asymptomatic people from hospital without a COVID19 test in early March, not least because discharging well or stable patients was the usual and sensible practice and asymptomatic COVID and was largely unknown at this time.

43. As the pandemic progressed our concerns about the impact of COVID19 on those with vulnerabilities increased and during the later part of March 2020 I recall being made aware of the rising numbers of people with COVID19 in care homes. In the CTMUHB area we had introduced COVID19 testing for all patients prior to discharge by 9 April 2020. I think the formal Welsh Government guidance was issued on 14 April 2020. Testing routines were monitored and changed as new information came to light, for example where patients were coming into hospital for planned care testing for COVID19 and an isolation period was introduced. Later still we introduced small scale random testing of staff for COVID19 in high-risk areas of hospitals. In referring to the Gold Command Decision Log on 21 May 2020 I recall we agreed that the random testing of asymptomatic CTMUHB staff would be accelerated by 50% from the week commencing 26 May 2020.

Impact on hospital care

44. As far as I can recall, the majority of Welsh Government decisions impacting on hospital care were discussed through our Welsh Government/CEO group. Inevitably some decisions were more problematic to implement than others and at times agreed guidance development took longer than I would have liked. However, our ability to continue to implement actions at a local level whilst awaiting guidance was not fettered and we were able to continue our path whilst understanding that should the awaited guidance differ from our practice, further change might be necessary. I would stress that the level of ongoing discussion meant that any differences were likely to be very minor. I seem to recall that guidance delays usually pertained to difficult ethical issues for example DNARs and criteria for admission to ICU.

45. We also had guidance delays where agreement was sought between the four countries, however common approaches where possible, in my view, was the right thing to try to achieve. The way we worked in Wales, which I have outlined above, was through expert or task groups usually with representations from our organisations. For example, clinical issues were advised through the leadership of our clinical Executives and leaders and advice, guidance, and actions would be taken by our Welsh Government/CEO group. In my opinion this mechanism worked reasonably well albeit gaining agreement across professions and organisations would sometimes take more time than we wished.

46. There were so many issues for us; revising clinical pathways; ensuring protection for patients and our staff; commissioning field hospitals with operational clinical protocols and full staffing; greatly increasing ICU capacity (physical environment; resources; equipment; staffing); responding and supporting our staff members' fears and concerns so they could care for patients; finding ways to enable staff mass-testing units alongside all the clinical care changes; and finding ways to reassure our communities. I found the Welsh Government supportive, helpful, providing leadership and recognising the hugely difficult position we were all in and the very difficult job everyone was trying to do.

Responding to Increased Infection Rates

47. From March 2020, the pace of change was significant. The staff I worked with both locally and nationally were tremendous, pulling together to try to respond the best we could to the

situation. In that time our local emergency plan attempted to cover as much as we could to keep staff, patients and the wider population safe, protect their health and wellbeing, and prevent deaths from COVID19.As the number of people infected with COVID19 increased and the pressure on our staff increased, the help and support from our communities to enable staff to care for sick patients increased.

48. So many issues were being worked on in parallel during that first wave. The Welsh Government facilitated support to us from the military given their expertise on large scale, rapid planning and deployment, and I found their help very valuable. Testing capacity for staff and potentially infected members of the public had to be increased significantly as well as delivering a quadrupling of our intensive care capacity and almost a doubling of basic hospital capacity. Field hospitals with a model of care delivery and staffing were created to enable this. These were huge and challenging tasks for us in a very short time period with no previous experience of this sort of activity whilst, as I have previous said, trying to keep health care and services available to all.

49. I stood our emergency response structure down on 21 May 2020. We had already started to work with the learning from the first wave. Equality impact, vulnerability, at-risk groups, mental health and wellbeing were all important areas of work and well recognised by Welsh Government, with guidance continually being developed and updated by them for us. The preparation for the second wave and potential subsequent waves of infection was able to pay more attention to these areas. The resilience of our staff was an increasing concern going forward as the same staff who had worked tirelessly through the first wave now needed to prepare for further subsequent waves, they had to re-introduce care and services which had been necessarily suspended, often having to provide services in new ways and of course they all had the same fears and many of the personal experiences of COVID 19 as had people in our communities. We asked a lot of them and continue to do so.

Test and Trace

50. From May 2020 onwards we undertook further preparation for subsequent COVID19 waves alongside work to restore as many services as possible back to capacity in a safe way. We worked through all of the consequences which had emerged in the first months of the pandemic. Our mechanism of working with specific Wales wide groups with Welsh

Government was continued, the pace of implementation continued to be worked upon and the work on the sequelae of the decisions made and how to restore services assumed a greater importance.

51. The importance of developing our capacity for test and trace continued at pace with much discussion over the priority list for including more and more groups of people for testing so that we were eventually mass testing the general public. Creating capacity for testing was a logistical challenge particularly for turnaround times for results in the first few months, which were just too long to be effective particularly for staff groups and patient discharge. The laboratory testing for our samples was conducted at a Wales level by PHW. As the pandemic progressed and our mass testing centres became operational, working with our local authorities was particularly fruitful. Collaborative working across public sector agencies was supported and facilitated by Welsh Government. Again, as with most of our work in Wales I found the discussion with Welsh Government officials, fellow NHS organisations and other public sector organisations constructive and supportive but not without its challenges.

52. In general, with respect to Welsh Government over the period I was working (January to August 2020) I found communication was good, consultation and discussion open. There were many difficult decisions with serious consequences which had to be taken and none were taken lightly. We did not always get decisions right, nor did we foresee all of the sequelae to decisions. However, as unforeseen issues arose, we dealt with these to the best of our abilities and tried with everything to keep a very open mind, understanding that we could not get everything right in this situation.

53. I provided evidence on behalf of CTMUHB to the Health, Social Care and Sport Committee – Fifth Senedd on 10 July 2020 about our experience of the first wave of the pandemic. *(Document References: SH/3 / INQ000283225 and SH/4 / INQ000283226)*. I am unable to comment on how the Welsh Government's approach changed over the course of the pandemic owing to the date of my retirement on 31 August 2020.

Reflections on the COVID Pandemic Response

54. There are five reflections which I would like to offer to the Chair of the Inquiry for her consideration. These are issues which in my opinion should be addressed going forward:

a. Pandemic planning must assume a high priority and robust plans developed, regularly rehearsed, refreshed and resourced.

b. There must be a competent and adequately resourced public health system in place working across the health and care sectors.

c. The health services and other public sector services need modern, usable and joined-up data systems (surveillance, data collection, analysis and sharing) with a modern digital infrastructure.

d. Research into infectious agents, vaccines and sequelae of epidemics and pandemics must be strengthened.

e. Decision-making at a national level (UK), regardless of the politics of the government of the day has to have respect and regard for science and a will to work closely with the devolved countries.

Statement of Truth

I believe that the facts stated in this Witness Statement are true and accurate to the best of my knowledge and belief.

Signed: **Personal Data**

Date: 12 October 2023

Exhibits

SH/1 / INQ000283222	COVID 19: Final Gold Command Closure Report signed off by Chair – 08.07.2020, including the following appendices:
INQ000283210	Appendix 1 - Appendix 1 - Strategic, tactical, operational management arrangements version approved at Gold 09042020
INQ000283211	Appendix 2 – Covid Decision Making Framework – final as approved at Gold on 23032020.
INQ000283212	Appendix 3 – Communications Strategy approved at Gold on 30042020
INQ000283213	Appendix 4 – C10.Final Status – Gold Work Programme – 21052020
INQ000283214	Appendix 5 – Gold Command Closure – Transfer of Activities and Actions
INQ000283215	Appendix 6i – Final Covid-19 risk and Issue Profile Report
INQ000283216	Appendix 6ii – Final Covid-19 Risk Log
INQ000283217	Appendix 6iii – Final Covid-19 Issue Log
INQ000283218	Appendix 7i – Gold Command Closure Lessons Learnt
INQ000283219	Appendix 7ii – Final Lessons Learnt Log 21.05.2020
INQ000283220	Appendix 8 – Final Covid19 Decision Log Summary
INQ000283221	Appendix 9 – Final Library Index Covid-19
SH/2 / INQ000283223	Correspondence from the Director General Health & Social Services / NHS Wales Chief Executive to CEOs of NHS Local Health Boards and the Welsh Ambulance Services Trust. “Covid-19 NHS Planning and Response”, dated 5th March 2020.

SH/3 / INQ000283225	COVID-19: Evidence session with Cwm Taf Morgannwg University Health Board and Hywel Dda University Health Board: Transcript Health, Social Care and Sport Committee - Fifth Senedd 10/07/2020 - Welsh Parliament (assembly. Wales) https://record.assembly.wales/Committee/6360
SH/4 / INQ000283226	COVID-19: Evidence session with Cwm Taf Morgannwg University Health Board and Hywel Dda University Health Board: CTMUHB Research Brief submitted to the Committee.