Witness Name: Glyn Jones
Statement: 1
Exhibits: GJ1-7
Date: 24 August 2023

IN THE MATTER OF THE UK COVID-19 INQUIRY
AND THE INQUIRIES ACT 2005
AND THE INQUIRY RULES 2006

UK COVID-19 INQUIRY

WITNESS STATEMENT OF GLYN JONES

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1. I, Glyn Jones, formerly Interim Chief Executive Officer, Aneurin Bevan University Health Board, provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18 May 2023, and will say as follows.

Background and qualifications

2. I have a Degree in Accounting and Finance and am a member of the Chartered Institute of Public Finance and Accountancy. I also have qualifications in Strategic/Finance Leadership and value based healthcare from CASS Business School and Harvard Business School respectively. I have over 20 years' experience working in the NHS in various senior leadership roles. In May 2010 I joined Aneurin Bevan University Health Board (hereafter "ABUHB") as Assistant Finance Director (Operations). I spent five months as Interim Finance Director in Powys Teaching Health Board from April to August 2016 before returning to ABUHB as Director of Finance and Performance in September 2016. I also took on the role of Deputy Chief Executive in July 2018. From November 2021 to September 2022, I was Interim Chief Executive Officer (CEO) in ABUHB before taking up the role of Finance Business Partner for the Royal Osteoporosis Society in October 2022. From May 2023 I took up the post of Director of Finance, Planning & Performance at Health Education and Improvement Wales (HEIW). I attach my CV as exhibit **GJ/1 – INQ000220324.**

Role as Chief Executive of Aneurin Bevan University Health Board

3. As set out above, in November 2021 I was appointed Interim CEO of ABUHB, having been the Deputy CEO from July 2018. When the pandemic began in January 2020, I was Director of Finance and Performance and Deputy CEO of ABUHB.

4. ABUHB is one of the seven Welsh Local Health Boards responsible for planning, securing and delivering primary, community, mental health and acute hospital health services in Wales and acts as both commissioner and provider of services in its area, with consequent responsibility for the health of the local populations. ABUHB is responsible for the local populations of Newport, Torfaen, Monmouthshire, Caerphilly and Blaenau Gwent.

5. The Chief Executive Officer (CEO) is the Accountable Officer for Aneurin Bevan University Health Board with full responsibility for the continued development and management of the Health Board. The Chief Executive provides top level leadership, vision, inspiration and strategic direction and management across all aspects of the Health Board's activities. In my role as Interim Chief Executive, it was my responsibility to ensure that all required decision making, control, delivery and development systems were in place. I was accountable for providing advice to the Board on all elements of Health Board business and specifically on matters relating to probity, regularity and administration. As one of the cadre of senior leaders within Wales, I was also responsible for contributing to the wider health and organisational agenda of NHS Wales and Welsh Government ("WG"), including working with Public Health Wales ("PHW") and other agencies to lead on the improvement of population health, reduction in health inequalities and the broader public health agenda. I exhibit to this statement a copy of the CEO job description as **GJ/2 – INQ000220323**.

6. The Chief Executive also takes a lead role at a national level. This includes being a member of the NHS Wales Leadership Group, working with the NHS Wales Collaborative (hosted by PHW), and Welsh Government. These responsibilities extend to leading and delivering as the senior responsible officer (SRO) on wide-reaching NHS public service initiatives. As Interim CEO I took over from Judith Paget as the CEO lead for the National Strategic Programme for Primary Care and the SRO for the roll out of 111 Cymru. I also took a national lead on the all-Wales Cardiac Network and all-Wales Lymphoedema Group.

Overview of Relationship with Welsh Government

7. During the time that I was Interim CEO of ABUHB there were regular meetings between Chief Executives of NHS bodies across Wales and Welsh Government officials. We met as CEOs on a weekly basis, normally every Monday. These meetings would be fairly

quick informal meetings of about half an hour to an hour. The focus of the discussion was on Covid issues and any other system pressure issues and a brief set of notes was produced by the NHS Confederation after these meetings. I do not hold a full set of these documents which I understand are held by the WG.

8. These weekly meetings would be chaired by the Director General, Health and Social Services Group and Chief Executive of NHS Wales, who was Judith Paget at that time, and would usually be attended by a few officials from WG including the Chief Medical Officer (CMO) and/or Chief Nursing Officer (CNO) and officials representing finance, performance and planning. The membership would vary depending on the focus of the meeting. For example, if there was a particular focus on public health issues the CMO would attend and might present on the national position; if the focus was more around recovery and elective services, the CMO may not have attended.

9. The CEOs of each of the NHS Wales statutory organisations and WG officials also met at monthly meetings. These meetings, referred to as the NHS Wales Leadership Board meetings were chaired by the Director General/Chief Executive NHS Wales. The Deputy CEO of NHS Wales and Director of Finance would also be there along with other senior officials from the Health and Social Services Group of WG. An agenda would be circulated ahead of these meetings and would include a number of Covid related items as well as broader system issues. The Leadership Board meetings were fully minuted and there would be papers to support many of the agenda items. I do not hold a full set of these documents which I understand are held by the WG.

10. The weekly meetings were more informal in terms of an agenda and papers and were more a response to service issues, some related to Covid and some related to emergency care. For example, if there was an issue with high levels of ambulance waits outside Emergency Departments, or if there was an issue regarding Covid infections this would be raised in the weekly meetings. The monthly meetings were more formal and structured in terms of an agenda and papers and addressed 'business as usual' topics. There were still matters discussed around Covid but this was more in relation to the medium term, looking at the weeks and months ahead, rather than how we get through in the immediate to short term.

11. I did not attend any UK wide committee meetings or any Wales-wide committee meetings, save for these weekly and monthly meetings with WG and all CEOs across Wales.

Engagement with Welsh Government

12. In the period from November 2021 to May 2022, I attended all monthly Leadership Board meetings save for the meeting in April 2022, which was attended on my behalf by the Deputy CEO, Nicola Prygodzicz. These meetings addressed a wide range of topics such as NHS finance and performance and also provided an opportunity to share information about the WG and NHS response to the pandemic.

13. At the beginning of November 2021, the UK was coming out of the second wave and it was just prior to the Omicron wave being declared. Towards the end of November there was a lot of interaction between ABUHB and WG in weekly and monthly meetings about system recovery. We were doing a lot of work around how we recovered and restarted lots of routine and non-urgent healthcare services. We were also planning for the impending winter. Typically, the NHS has a winter planning cycle. We were conscious of what the workforce and communities had been through in terms of Covid and we were expecting a challenging winter period. We were making plans to build in as much resilience in the workforce as possible.

14. Along with other CEOs, I was given the opportunity to discuss and provide feedback to WG on draft guidance, action plans and service improvement programmes at these meetings so that matters raised in discussion could be considered by WG. I have set out below a summary of the discussions at the meetings attended by me that are relevant to the pandemic response. I attach copies of the minutes of the NHS Leadership Board meetings from November 2021 to May 2022 as exhibits **GJ/3a – INQ000220314, GJ/3b – INQ000220315, GJ/3c – INQ000220317, GJ/3d – INQ000220319, GJ/3e – INQ000220320, GJ/3f – INQ000220321 and GJ/3g – INQ000220322.**

    a. On 23 November 2021 there was a discussion about WG's Six Goals High-Level Strategic Action plan for urgent and emergency care during which I expressed the view that the actions in the plan were helpful and we needed to try and sustainably address them, but noted this will be difficult for Health Boards who will do their best. We also discussed what more would be done on transferring patients out of hospitals and colleagues stressed the importance of a whole system response in

addition to the need to look at the language of the plan so that it was received as a plan to support and guide frontline workers and not tell them how to do their jobs. It was agreed that a comms plan would be drawn up and circulated in the hope that the work could be moved forward before Christmas and this item would be included on the agenda at the next Leadership Board meeting on the 21 December for a further update and for review of the final version, reflective of the Board's comments.

b. At the meeting on 21 December 2021 there was a focus on the increased prevalence of the Omicron variant of Covid-19.
    i. WG shared the latest modelling data with the Board. I asked whether there was any modelling on workforce absences in health and social care and we were informed that the very worst case scenario for sickness absence would be 30% and the modelling suggested at any one time that 12% of staff could be absent with Covid-19.
    ii. Judith Paget explained that she had recently written to Chief Executives to ask them for their system resilience plans and readiness to deploy field hospital capacity if it was required. WG's Delivery Programme Director, Andrew Sallows, thanked colleagues for their returns and gave a brief overview of the current situation across Wales.
    iii. It was explained that WG wanted to offer a booster vaccine to all eligible people by 31 December 2021 and the NHS Wales Director of Operations, Jeremy Griffith, shared a slide on the current progress in the vaccination programme. Judith Paget confirmed that work on the next phase of the vaccination programme would recommence in the New Year.
c. On 25 January 2022 the Minister for Health and Social Services attended the meeting at which the discussion included the current operational issues related to Covid-19, the vaccination programme and recovery and redesign of the urgent and emergency care system. It was noted that Covid rates were falling and sickness absence had reduced and the Deputy CMO stated that discussions were taking place in relation to isolation periods and testing requirements for staff, hospital patients and care home residents and they hoped to achieve a degree of alignment and consistency with the public position. The Minister expressed her thanks to colleagues for an incredibly successful booster vaccination programme, she acknowledged the huge pressures on urgent and emergency care and thanked colleagues for their efforts on planned care.
d. On 22 February 2022 the Leadership Board were informed that WG was working on its plan on how to move forward from the pandemic and this was likely to be

published on 4 March 2022. There was a run through of WG's Transformation Road Map which illustrated several phases including discover, design and develop. We were informed that much of the work was government heavy as it relied on extensive policy and strategic work but this would be developed in a co-construction approach through a series of task and finish groups with a role for governance and operational delivery. I thanked colleagues for a helpful update and suggested that given the current uncertainties, we needed to be flexible with our workforce and asked for regular updates on any intelligence that WG received on the changing situation re: Covid-19 response. A further discussion took place regarding the recovery and redesign plan for urgent and emergency care and the meeting was informed that comments would be reviewed and a further iteration of the paper prepared for the March meeting with a view to the Minister publishing the plan in April.

e. On 29 March 2022 the CMO explained that Covid-19 cases were increasing and there appeared to be high rates of reinfection. The Deputy CMO explained that there had been an update to the hospital testing guidance and this had been shared with the NHS for implementation. The final draft of the urgent and emergency care paper was circulated for discussion and approval and the Board were content to proceed to implementation providing the impact and consequences were kept under review. It was agreed that feedback would be shared with the Board on a quarterly basis. The Director General explained that the Minister would be re-launching the Six Goals for Urgent and Emergency Care on 27 April 2022.

f. On 24 May 2022 the Deputy CMO explained that Wales was seeing the lowest numbers of patients with Covid in hospitals since August 2021. As part of the discussion on recovery and redesign, Carol Shillabeer, CEO of Powys Teaching Health Board, stated that by mid-June there would be a targeted plan to increase capacity by 1000 beds or bed equivalents. The Board was also told that it would be important to maintain a core workforce to deliver vaccinations moving forward and further work was being undertaken in relation to funding and value for money.

15. Save for the Leadership Board meeting in January 2022, I did not have any contact with Ministers when Interim CEO nor did I ever give evidence to Senedd committees about Covid; however, I did meet regularly with the local Senedd members (MSs) and MPs. The meetings with MPs and MSs were normally less frequent but during the pandemic we increased the frequency from once a month to once a week. Along with executive colleagues, we would meet for about an hour via MS Teams. The meetings were about

sharing information with local MPs and MSs about the types of things they would get calls about from constituents such as infection rates, how many patients were in ICU in hospital, where vaccination centres were open and testing locally.

16. These meetings provided a way of communicating key messages to local politicians, particularly around Covid, and it was an opportunity for them to ask questions of us about any issues such as restrictions and what was going on with the vaccination programme. We had two-way conversations and these meetings provided the Health Board with an opportunity to get feedback from members of the public locally and were also a good way for the Health Board to spread key public messages. It was really helpful and they found it useful. The feedback from MSs and MPs was very good and they would often use their own political platforms to spread some of these informative messages, such as opening times for vaccination centres, and they would sometimes reinforce messages. I started to reduce the frequency of these meetings as Covid became less of a pressing issue.

17. Following these meetings, I would provide a briefing note for MPs/MSs summarising the information shared during the meeting which MPs/MSs could use in their own social media messages. I do not hold a copy of these documents which I understand are held by ABUHB Within those notes, I would include:

    a. The incidence of covid infections within ABUHB communities;
    b. The situation within ABUHB hospitals, including the number of patients who had tested positive for Covid-19, the number awaiting results, the number previously diagnosed with Covid-19 and the number of patients being treated for something other than Covid-19;
    c. The situation within care homes;
    d. The status of the mass vaccination programme, including details of the date and location of vaccination clinics and an update on current JCVI advice on vaccinations for particular groups such as children;
    e. An update on current self-isolation requirements;
    f. Details of visiting arrangements for ABUHB hospitals and care homes; and
    g. Details of any service changes.

18. There were a couple of instances where I exchanged some text messages with Judith Paget, Director General/Chief Executive of NHS Wales in order to keep her informed about what we were doing locally. One exchange on 30 December 2021 was around PCR testing and extending the testing centre at Rodney Parade which I have set out below:

"Hi Judith - just wanted to let you know that we have agreed to reuse part of Rodney Parade for sample testing for NHS/LRF staff for the next month, given the increased demand. It should be a positive story if the media pick it up. BW Glyn

That's useful to know. Just for your information PHW are looking at ways of reducing demand for PCR given current demand and have given suggestions of how this might be achieved…it might move quite fast. Will let you know if anything is proposed that impacts of staff testing requirements. BW Judith

Okay thanks – we will have it in place tomorrow but can always scale it back or take it down if that is the case. Thanks Glyn.

That's great – it's a good idea..."

19. The other occasion on which we exchanged text messages was when we had the Omicron wave and WG announced in mid-December that we must offer anyone eligible a vaccination by the end of December 2021. That was effectively a target we were all trying to deliver or meet and I remember sharing text messages with Judith Paget at that time. Initially I was not sure that ABUHB would be able to meet that target but a couple of days later I was able to confirm to her that ABUHB was on track to offer everyone a vaccination appointment by the end of the year. It was an effective way of communicating quickly, often outside normal working hours. I exhibit all of the text messages exchanged with Judith Padget between November 2021 and May 2022 as **GJ/4 – INQ000220326.**

20. WG representatives also communicated with me via email either following a meeting we had or if there was something specific about our Health Board, particularly if it was in relation to service delivery or funding. I have submitted all the emails which relate to key decisions during between November 2021 and May 2022. For example:

    a. On 13 December 2021 I received an email from Simon Dean, Deputy Chief Executive of NHS Wales following up on the CEO conference call earlier that day in which he reinforced that WG was moving into a new phase of its Covid-19/Omicron response and Health Boards were reminded that it was vitally important that every step was taken to maximise the size and use of the available workforce, prioritise the further acceleration of the vaccination programmes and develop capacity plans for any surges in hospital admissions. All Health Boards

were asked to review and maximise use of the Local Options Framework and workforce flexibilities and all non-essential meetings were stood down to assist with this. **GJ/7a- INQ000282339.**

b. On 1 February 2022 I received an email attaching a letter from the Director General/Chief Executive of NHS Wales to all CEOs in which we were informed that the UK Infection Prevention and Control guidance had been reviewed and FFP3 masks should be supplied to all NHS staff engaged in aerosol generating procedures and in other circumstances where a local risk assessment suggests a continuing risk of infection transmission despite other protective measures being in place. **GJ/7b.1 - INQ000282337 and GJ/7b.2 - INQ000282338.**

c. On 14 February 2022 I received a letter via email from the Director General/Chief Executive of NHS Wales setting out the WG expectation that all Health Boards would continue to implement the vaccination programme and JCVI advice on delivering booster doses to the immunosuppressed, the elderly and vulnerable and to at risk children and children who were household contacts of the immunosuppressed. Health Boards were also asked to plan for the 'most likely scenario' set out by WG in the Planning Framework and reassured that WG would centrally fund vaccination costs for the coming financial year. **GJ/7c.1 - INQ000282340 and GJ/7c.2 - INQ000282341.**

d. On 21 February 2022 I received a further letter via email from the Director General/Chief Executive of NHS Wales with an update on the JCVI advice on delivery of the spring booster and eligibility criteria. It was noted that the JCVI advice was narrower than the scenario WG had asked Health Boards to plan against and we were advised that it would be prudent to continue to plan against the wider definition in case the JCVI were minded to widen the eligibility criteria. **GJ/7d.1 - INQ000282352 and GJ/7d.2 - INQ000282353.**

21. I did not communicate with WG representatives by any other means such as WhatsApp. Generally, because the meetings were frequent, if there was anything urgent that came up, Judith Paget and I would tend to exchange text messages to keep one another informed, and if there was anything she wanted to be briefed on or was concerned about she would text me or vice versa.

22. I don't think the way I communicated with WG hugely changed over the course of the pandemic, although the nature of what was communicated probably changed. As set out above, at the beginning of November 2021, the focus was on recovery and restarting services and planning for winter. This quickly changed in early to mid-December 2021

when we were aware we were into the Omicron wave. Very quickly then, we were refocusing and redeploying staff to deliver the vaccination programme and offering vaccinations by the end of December with the aim of vaccinating people as quickly as possible. There was a lot of discussion within the organisation as to how we redeployed staff to achieve that.

23. Usually, due to the annual planning style, when going into March and April it was more about planning for the forthcoming financial year regarding services and elective services in particular. In the course of the pandemic, communication and the frequency of meetings was the same but there was a shift in the content of the discussions. It was around the end of February 2022 that we got through most of the mass vaccination programme and then we were back into looking at recovery and restarting elective services. We were managing the tail end of winter pressures and trying to get back to business as usual. Although Covid was still very much in the community and healthcare system, we were then looking at a decreasing trend in infection rates and patients in hospital.

24. I did not influence or try to influence the timing of the rollout of the mass vaccination programme as I generally agreed with the aim to vaccinate those eligible as soon as possible. For me as Chief Executive of ABUHB it was more about local issues and trying to ensure we could implement the programme. The discussion with WG at the weekly meetings in November and December 2021 was about what facilities and staff we had and WG encouraged all Health Boards to review field hospital capacity due to concerns about the increasing rates of transmission with the spread of the Omicron variant. On the delivery of vaccines, there was a general consensus that we had to vaccinate the population as quickly as possible and what was under discussion was how to do it in the most effective and safe way. This obviously had implications for other services. If we had staff who could contribute to the mass vaccination programme, we actively looked at redeploying people away from routine non urgent services so they could work on the vaccination programme. Again, discussions with WG were more about the consequences of redeploying staff as it meant we had to temporarily stop some of those routine non urgent services.

25. There was a framework WG produced – a Local Options Framework - about how and when we might consider stopping routine services to support the Covid response. This was sent to ABUHB by Andrew Goodall, Director General/Chief Executive of NHS Wales, in December 2020 and remained in place during my tenure as Interim CEO of ABUHB.

On 13 December 2022 all Health Boards were asked by WG to actively review and maximise the use of the Local Options Framework and on 16 December 2021 Judith Paget wrote to all Health Board and Trust CEOs asking for weekly updates on the impact of the Omicron variant on services including the vaccination programme, urgent and emergency care, critical care, primary and community care and patients who are medically fit for discharge. There were a few occasions that we used the framework in our strategic meetings when we made a decision either about temporarily stopping certain routine services or consolidating them so we could then redeploy staff on priority services like vaccination. All decisions made under the Framework were recorded on a spreadsheet template and were shared with WG. In the weekly meetings we could then see across Wales how each Health Board and Trust was using the Framework. I attach a final and completed copy of the Systems Resilience Reporting letter and template as exhibits **GJ/5a – INQ000220316 and GJ/5b - INQ000220325.**

26. At one stage we were updating the template weekly and sharing this with WG. This would also be taken to the Gold/Strategic meeting every week where the service changes would be discussed and some decisions would then be taken to the Board or reported to the Board retrospectively depending on the nature and scale of the decision. We would also have approached and consulted with the Community Health Council (CHC) regarding any decisions under consideration.

27. During the period that I was Interim Chief Executive, I was not involved in any discussions with WG about lockdowns or restrictions. By that stage I think WG was comfortable taking advice from others and announcing decisions regarding the Omicron variant. There were discussions about the delivery of the mass vaccination programme but it was not so much influencing what should be done but rather discussing how we were going to deliver that given the high number of vaccinations needed.

28. When I was Deputy CEO, I did join one meeting with the First Minister, Health Minister and leader of Torfaen local authority, at which there was discussion about a local lockdown. This happened during the second wave in autumn 2020 and not during the time that I was Interim CEO. After the first wave in 2020 there were a number of things that happened so that when we got to the second wave there were a lot of local restrictions. WG placed individual local authorities into restrictions - different local authorities had different restrictions depending on the level of Covid in that area. It was a very different approach and as part of reaching a decision, WG would meet with the CEO

of the relevant Health Board and leaders from the relevant local authorities. It was about getting advice from the local authority and Health Board which would be taken into account when making a decision whether to place that area under a restriction.

29. I did not give any formal advice to WG, but there may have been advice provided to WG by other members of the Executive Team such as the Director of Nursing who had peer group meetings with the CNO and the Director of Public Health who had peer group meetings with the CMO. There were no meetings that I can remember where I was specifically asked to give a view or opinion on any of the guidance published by WG. At that stage it was more clear-cut in terms of what had to be done and what we had to do, and so it was more about how to implement things rather than giving advice on whether they should be taking those decisions.

30. I found the frequency of meetings with WG over the course of the pandemic really helpful. The monthly meetings allowed us to forward plan whereas the weekly meetings were more reactive looking at what happened last week, what was happening in the current week and what was planned or might happen in the next week. Where announcements were made, guidance was coming out or advice was changing, the weekly meetings allowed us to discuss and share any issues. We had an opportunity to raise any difficulties anyone was experiencing. I found the meetings very helpful in that respect and they tended to complement the arrangements we had in place locally.

31. I have thought long and hard about whether things could have been done better. I have thought about whether we could have been made aware of certain things sooner, but on reflection, I think the communication between ABUHB and WG was very good. The frequency of our meetings was such that it meant that we had a regular dialogue going and because the Director General/Chief Executive of NHS Wales and I knew each other, we could pick up the phone or send an e-mail. I am struggling to think of anything that, objectively, I could say WG could have done better.

32. When considering the Omicron wave, I am not sure from a timing point of view whether WG was aware of scientific advice sooner than they made us aware of it. From my point of view, when WG made the announcement that they would offer a vaccination appointment to everyone by the end of the year, that was around 12 December, we had to gear up to deliver most of the programme by the end of December, only two to three weeks later. Whether in hindsight they could have made that announcement earlier, I

don't know. However, when the announcement was made, cooperation and communication between us worked really well.

33. In relation to the collection and sharing of data and information with WG, that was usually shared outside the meetings referred to above. Locally we had various performance dashboards we would produce, some on a daily basis, some for the Strategic/Gold group and others around the Tactical/Silver group. On a daily basis I would have access to a range of different performance indicators related to Covid. These would come from different systems but would look at the number of infections in the community locally and around our services, i.e. patients in hospital testing positive for Covid, how many were in ITU and how many were recovering. There was lots of staff testing data and data regarding care homes. A lot of that was collected through this performance dashboard but there were also other information systems we used to draw all that information together. When we had our Gold/Strategic meetings, we would use the dashboard as a reference so we understood what was going on and how we were responding locally. The Gold/Strategic meetings would also normally consider WG guidance which may have come out.

34. There were information systems that fed into WG so they had the same data as us. I don't believe the WG had direct access to the dashboards but the dashboards drew information from a range of different systems, some of which were national systems. Information about infections in the community would come from the public health systems – the same source of information as WG but we would focus on ABUHB – and some of the hospital and community information would come from our systems, and it was then shared with WG. Some of the data we were getting on care homes was generated locally and this was also shared with WG.

35. Some of that data was shared via returns requested by WG, through ABUHB's information and performance teams or in bulletins from WG about providing data every day or week. At one time in the early stage of the pandemic, we were trying to provide daily information to WG on patients in intensive care which literally required someone to do a trawl around the ITUs to make sure the information was up-to-date. That became quite onerous. However, most of the information systems we were able to automate and so returns became easier over time.

36. There was guidance early on in the pandemic about data sharing but most of that was in place when I became Interim CEO and if new guidance came out, responsibility for

actioning it would have been delegated to the Performance and Information Teams. However, once I was in post as Interim CEO the Health Board had systems up and running and they were working satisfactorily. The systems were robust and I do not recall any issues.

37. With the changing nature of the pandemic the frequency with which WG needed information from the Health Board changed from time to time. For example, on 4 November 2021 WG sent a letter to all CEOs notifying us of an additional requirement to provide paediatric capacity data as part of the daily Covid-19 capacity reporting and on 1 December 2021 I received a letter by email from the Director of Delivery and Performance, notifying the Health Board of WG's decision to reinstate reporting on equipment capacity and usage over the winter period. If something came through in a WG circular or guidance, I would tend to circulate that to the relevant people for it to be actioned, but at the very least I would record and minute that as part of the Gold/Strategic meetings so everyone attending was able to access the guidance circulated. If it was significant, it would be discussed as an agenda item.

38. By November 2021 I think we were in a better position and I am struggling to think of anything where there was a real problem with data. In the first wave, maybe some of the modelling data could have been shared earlier but at that time, everyone was trying to work out what was relevant and helpful. During my period as CEO, we were a lot more on top of being able to record, collect and use relevant information. Some of the systems were quite well embedded at that point in terms of knowing what was going on in hospitals and in the community in relation to infection rates generally and the information systems within the health board worked quite well. The vaccination programme had up-to-date information on who was vaccinated, age groups and ethnic background to show how the vaccination programme was being delivered across the Health Board area.

39. WG modelling and data was coming to the Health Board in an organised and systemic way and as well as seeing what was happening locally, we were also seeing, through weekly meetings with WG, what was happening elsewhere in Wales. We could see as a Health Board if we were at the front end of the wave or the back end and it helped to inform discussions relating to that and showed trends. We could see if it was getting worse or better and we could see if another Health Board was seeing an increase in the incidence of Covid infections such that it was probably only a matter of time before it spread across Wales.

40. The WG modelling and data was usually provided as a slide pack with graphs and data. A lot of the data was shared in confidence and was not shared beyond the CEOs. The weekly meetings with WG were a forum in which we could ask questions about that data. For example, if we were looking at public health surveillance data the CMO and CEO of Public Health Wales would attend the meeting and there would be an opportunity to ask questions and get a sense of what was happening elsewhere in Wales and across the four nations. It allowed us to start thinking ahead about what our response might be. I attach an example of the modelling and data shared by WG in a slide pack dated 11 February 2022 as exhibit **GJ/6 – INQ000220318.** I do not hold a full set of the slide packs but understand that these are held by WG.

41. I did not have any direct involvement with technical advisory cells or groups (TAC and TAG), but the Director of Public Health and possibly also the Director of Planning would have. They would then report back to the Gold/Strategic group and at the point that we could share the modelling data, we would often use the same WG slide packs or take relevant information from it. We would use that data with the data we had locally to look at trends and try to forward plan and formulate what might happen, looking at time lags and performance indicators. For example, if there was a time lag of 10 days from infections going up to presentation in hospital, it would allow us to start planning for capacity in the ICUs.

42. When we were going through the Omicron wave, it felt different and we had concerns about how effective the vaccine would be. It was therefore always helpful to have the WG modelling data and then look at our own local information to see how we would respond. If you take the first wave, we saw a lot of people going into ICU fairly early on. In the second wave, a number of our clinicians were reporting that they learned from the first wave and were able to manage patient care differently so there were less patients on ICU. By the time we got to Omicron the sharing of data meant that we were better able to plan for staffing and bed capacity. In fact, I felt that that helped in increasing the resilience of some services.

43. Once the sharing of data was embedded in the system, it seemed to work well. At the time of the first wave, we were still trying to get robust systems in place and were trying to make sure they were embedded. Some of the predictions in the first wave had been pretty worrying, but as we went through different lockdown restrictions and saw the impact, it gave us more confidence as to whether those predictions were robust enough. There was a potential when I was CEO that we were under-prepared for the scale and

complexity of a further variant of Covid when the Omicron variant was identified. However, by that time, even with the uncertainty around Omicron, I generally felt data was available and helpful in planning different service scenarios locally.

Non pharmaceutical interventions (NPIs)

44. I did not play any role in providing information, data, analysis or advice on decisions by WG concerning NPIs. When I was Interim CEO, there had been lockdowns at a national level during the Omicron wave but by that time it was clear that the lockdowns were needed and WG were prescriptive about that. When I was CEO, the main response to Omicron was to get people vaccinated, so locally, we were focused on how we delivered that. The timescales for vaccination were challenging, but it was much more about how we did it.

45. I was not involved in giving any advice to WG on working from home, although we had looked at our own arrangements within ABUHB in terms of working from home and there were also things like visiting restrictions where there was a degree of local discretion. I don't think I had any involvement in decisions regarding social distancing, restrictions on mass gatherings, school closures or any other NPIs.

46. I also do not think we were really asked for any advice on the use of border controls during my time as CEO. There were times when there were differences in restrictions between England and Wales which presented a problem in the sense that it generated queries from the public about the application of the rules in relation to accessing health care services and visiting patients, but not during the period that I was CEO.

47. There is nothing that I can recall in any meetings that I attended where we discussed health inequalities. However, if anyone within the Health Board had those discussions it would have been the Director of Public Health, possibly with her peers and the CMO.

48. I do not feel able to comment on whether WG gave sufficient consideration to the impact of NPIs on 'at risk' and other vulnerable groups in light of existing inequalities. There would have been particular risk groups affected by decisions such as lockdowns but I do not know what information or advice WG had in balancing those decisions. It is therefore quite hard to give an informed view on that, as I have not got any evidence to suggest that they made the wrong decision.

Local lockdowns and restrictions

49. Local lockdowns had been imposed before my time as Interim CEO but I do not recall being involved in any discussions about local or regional restrictions in the time that I was CEO. As described above, there had been lockdowns at a national level during the Omicron wave but given where we were with Omicron there was a general acceptance that it was probably the right thing to be doing.

50. In the period before I became Interim CEO, as mentioned above, I recall that there were issues caused by the differing restrictions in England and Wales and it would have been good to have more clarity as to what local lockdown meant. If an individual was in an area that was not in lockdown there were issues regarding how clear the guidance was about travelling through areas that were in lockdown. There were also border issues as some local authorities were in lockdown and others weren't and there was a level of confusion in communities as to what was allowed and what wasn't. We would have discussed these issues locally and in Strategic/Gold meetings we would have discussed what that meant practically, in particular for the workforce and also for patients where they were living in a lockdown area and then had to travel to an area that was not in lockdown. Differing restrictions made it difficult to manage patient care, visiting restrictions, travel and potentially discharge. The majority of these issues, however, arose before November 2021 and therefore before my time as Interim CEO.

Care Homes

51. In respect of care homes, the key issues were the availability of PPE and guidance on care home visiting, but they arose long before November 2021.

52. During the time I was Interim CEO, I would have had care homes in incidents that were not accepting new discharges from hospital but generally the trend was a decreasing one by that time and it was more about trying to manage and support the care home sector so that we were able to achieve discharge from hospital.

53. A lot of the work we did as a Health Board was sharing information with local MSs and MPs as they were the ones who were likely to get questions from local constituents about availability, visiting local care homes and why their loved ones could not go to a particular care home.

54. The only piece of work I recall being involved in was when coming out of Omicron in May 2022 when ABUHB was looking to build additional bed capacity across Wales. Carol Shillabeer in Powys Teaching Health Board was leading on this. We were looking at how

we could create nationally an extra 1000 beds across NHS Wales and as part of that we were looking at care home capacity as well as hospital capacity. We knew there was potentially bed capacity in the care home sector, albeit not necessarily the workforce capacity. That was a national piece of work which WG would have been working with the service on. The Health Minister was aware of it and we were working with local authority partners looking at residential care as well as looking at NHS continuing care in care homes. As we moved out of the pandemic, we were looking at how to create capacity to get a flow of patients discharged from hospitals back into the community.

55. The care home sector had been challenged prior to the pandemic and had been weakened further as a result of the pandemic. We were looking at how we could build that back up as part of increasing bed capacity. This was something CEOs across NHS Wales were driving rather than something that had been directed by WG. WG were looking at things like ambulance waiting times outside Emergency Departments and delayed transfers of care as part of the Six Goals for urgent and Emergency Care programme. We were conscious of that locally and we came together with an aspirational plan to try to create 1000 beds.

Impact on hospitals

56. By November 2021, when I took up my post as Interim CEO, as explained above, we had a national framework that allowed us to look at specific services that were under a lot of pressure and make decisions to change those services temporarily. When we had Covid infections in the community it impacted on staff levels of sickness and we were seeing in some services high levels of sickness. The framework allowed us to make decisions locally to consolidate the workforce or to relocate services. Maternity services and midwifery services provide a good example of where we used the national framework WG set in place and took decisions locally like consolidating some of our maternity services into the Grange Hospital and temporarily closing some of the Midwife led-units on other sites to give more resilience in the midwifery workforce.

57. We considered the decision to change maternity services through the strategic group and that was either taken through the Board and updates reported retrospectively if we needed to take further urgent decisions. We would have consulted with the Community Health Council, WG and local MPs and MSs. There was quite extensive engagement and communication but sometimes those decisions had to be made quickly to make sure the services were safe. It was all under the national umbrella and gave Health Boards a bit

of protection so that that we were able to make those decisions that we would not normally take in normal times. Contextually it gave us more protection as WG was explicitly saying that they recognised during these exceptional times that services may come under pressure and therefore if you follow the framework and have a sensible decision making process then it is reasonable for Health Boards like ABUHB to be doing these things.

58. As described in paragraph 25 above, on a weekly basis we were reporting to WG when we were using the framework. Some Health Boards, if they were under a lot of pressure, would cancel their routine surgery and they would then report that through this framework. There will be a lot of examples on this being used on an all Wales basis.

59. Prior to my time as Interim CEO, ABUHB had established a local ethics committee to give our clinicians some structure and governance around any tricky clinical decisions they had to make, including DNAR decisions. There was some discussion at Strategic/Gold meetings and the ethics committee would report into the Strategic/Gold committee meetings. ABUHB was often being hit first and hardest in Wales and we were often having to think ahead of any guidance from WG in the early days. It was therefore helpful to have the ethics committee and I felt the level of professional expertise here locally enabled us to get on and do the right thing. In those early days we were finding that sometimes we were feeding learning and advice into WG and cells were being established to enable WG to produce guidance for the rest of Wales.

60. A particular concern from around February 2022, which was discussed regularly in the weekly CEO Covid meetings with WG officials, was ambulance handover delays and the level of hospital bed occupancy which in early April 2022 was noted to be at its highest since the start of the pandemic. The principal bed constraint was the difficulty discharging patients, particularly into social care placements, and the focus became the national mission to expand bed capacity by 1,000 beds and WG's Six Goals High-Level Strategic Action plan for urgent and emergency care.

Test, Trace, Protect (TTP)

61. My high level overview of TTP is that it was a really good example of local partnership working. Over the whole period of the pandemic ABUHB were doing things in advance of the guidance, such as establishing a testing centre and even down to the level of testing patients and staff. We were probably taking our own view locally about what we needed to do. Early on, we were informing WG of the financial and workforce model required to implement TTP locally. We worked very quickly with local authorities to get teams in

place and I think it worked really well as a result of that. It was one of the big successes of the pandemic, the ability to work together as public sector bodies to deliver services.

Public health communications

62. The Health Board had and still have a significant following on social media. When I was Interim CEO, ABUHB had well over 100,000 followers on Facebook. We built a strong following on social media, not just patients, but local politicians and other media providers. We used social media to get information to our local population to know what was going on with the pandemic. I had a sense that a lot of people felt we were a trusted and reliable source of information. There was a feeling that if information came from the Health Board, particularly as we had clinical personalities seen as trusted experts, it could be relied upon.

63. Given that context, we used social media quite a bit when I was Interim CEO. It was more local or regional communications than national and we would promote the use of vaccinations. I did a Facebook Live interview outside one of the mass vaccination centres at Cwmbran Stadium on 12 January 2022 with Dr Mezz Bowley, one of the public health consultants who was leading the vaccination programme. I took the opportunity to reinforce the importance of attending for a vaccination and to thank staff and patients for their support for the vaccination programme.

64. The only other public communication I was involved in was my engagement with MPs and MSs as described above. Sometimes I was informing them of any recent WG guidance that had come out, but it was mainly informing them of what we were doing locally in response to the pandemic.

65. The other thing I responded to prior to being appointed Interim CEO was at the beginning of the pandemic, in around March 2020, when we were looking to use the Grange as a field hospital. I made a public statement which went out on social media, and probably also paper media, that ABUHB was in the process of building a new hospital and we were able to reschedule the construction work and allow access to inpatient beds in the Grange. We had to work through with WG how we could achieve that financially and there were press statements from the Health Minister and myself as Deputy CEO at the time.

66. From November 2021, WG's public health communications were generally good. It was challenging for us having to deliver a mass vaccination programme so quickly, but it was the right thing to do and I wholeheartedly support that decision. I can't think of anything

during that period where I thought WG's public health communications were inappropriate.

Lessons learned

67. Having reflected on my interactions and the interactions of the Health Board with WG during my time as Interim CEO, I consider that the joint working with local authorities and other local partners worked very well, such as establishing testing centres and TTP services and we had good working relationships with WG officials.

68. Prior to my time as Interim CEO some early data collection relied on manual, labour intensive processes and it was time consuming to provide daily information (sometimes seven days per week). As indicated above, most of the information systems were automated by the time I was Interim CEO and returns therefore became easier over time.

69. I consider it is important that the learning from the Covid pandemic is distilled into effective contingency plans for any future pandemics.

Statement of Truth

I believe that the facts set out in this statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD Dated: 24th August 2023