IN THE UK COVID-19 PUBLIC INQUIRY
Chair: Rt Hon Baroness Hallett DBE
Module 3

Witness Name: Philip John Kloer
Hywel Dda University Health Board
Statement No: 1
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WITNESS STATEMENT OF PROFESSOR PHILIP JOHN KLOER

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1. I am Professor Philip John Kloer, Interim Chief Executive. This statement is in response to the Inquiry's Module 3 Rule 9 Request seeking information on the impact of the Covid-19 pandemic on the way Glangwili General Hospital functioned during the relevant period. Throughout this statement I will refer to Glangwili General Hospital as GGH and/or the hospital.

2. Throughout this period I was Medical Director and Deputy Chief Executive of Hywel Dda University Health Board (referred to as HB or the Health Board). In that role my managerial responsibilities extended across the entire Health Board, including the four acute hospital sites within its geographical footprint. By way of background, I am a respiratory physician in the Health Board stepping away from clinical practice in 2021.

3. As Medical Director and Deputy Chief Executive, I was responsible for effective clinical practice and guidance and, along with other executives, for Quality and Safety and decision making across the organisation. During the pandemic my role was focused on the Health Board wide responses, including professionalism of doctors, interpretation of national guidance and systems for national guidance.

4. Of those four acute sites, Glangwili General Hospital is the largest providing secondary care healthcare services, principally for Carmarthenshire, but extending across the region. GGH has its own 'on site' management structure which meets regularly both internally and directly with the Executive Directors. In providing this statement I have obtained information and evidence from relevant GGH staff including, but not limited to, Dr Eiry Edmunds, Hospital Director/Consultant Cardiologist, Name Redacted, Head of Nursing, Sarah Perry, Hospital Manager, Dr Name Redacted, Consultant Anaesthetist and then Clinical Lead of ICU. I have also

obtained advice and assistance from Mrs Mandy Rayani, the HB's former Director of Nursing, Quality and Patient Experience.

5. As the Inquiry will know, healthcare services in Wales are divided into Health Boards, which are responsible for populations within defined geographical areas and then answerable through the Chair and Chief Executive to the Minister for Health and Social Services and the Chief Executive NHS Wales respectively.

6. Hywel Dda University Health Board (HB) is the integrated Local Health Board for West Wales and responsible for healthcare services in Carmarthenshire, Ceredigion and Pembrokeshire. These three counties cover a large footprint of 2,266 square miles and serve a total population of around 382,000. It is a low population density region, with few large urban developments and, relative to England, a high proportion of people over the age of 65. It is 'home' to some of the most deprived areas in Wales, the majority of which are located in the Llanelli region within Carmarthenshire, with areas of high to severe levels of health deprivation.

7. At the outset of this statement there are two general points worth making.

8. Firstly, and as a 'bird's eye' view, the role of the Board can be viewed as being responsible for culture and strategy, and holding the organisation to account for delivery, with GGH responsible for operational functions. So, for example, Infection Control Policy, when to test for Covid and who to test, was decided at Board level and then adopted, as uniformly as practically possible, across the four acute hospital sites. GGH did not create its own stand-alone policy.

9. The Health Board was, of course, responsive to national Guidance and hospital feedback. During the pandemic, when the Gold, Silver and Bronze Command structure was established, each hospital reported directly into the Acute Bronze Operational Group which then, in turn, influenced decision making at Silver Tactical and Gold Command level.

10. Secondly, because of the hospital's location, harboured in West Wales, there was a lag in the pandemic reaching West Wales during the first Covid wave which hit Carmarthenshire on or around 23rd March 2020 and then peaked at GGH on or around 27th April 2020. The predicted 'reasonable worse case scenarios' for staff, beds, medical equipment and supplies did not materialise. The national hospital discharge policy in early 2020, combined with the HB staff recruitment drive and closure of non-urgent and elective services, created sufficient capacity in the system at GGH.

11. There were still a number of challenges for the HB, but of a different type, such as concerns about whether we would have enough PPE, oxygen, ventilators, and CPAP machines, at a time when we had limited testing capabilities and no vaccines.

12. When the second wave broke, in October 2020, the hospital was operating at capacity and with few community options for patient discharge. Staff shortages combined with the outdated infrastructure at GGH placed all staff, particularly frontline staff, under great stress. Maintaining good care for all patients was difficult although I believe that the resilience built into the system, through staff recruitment, upskilling and redeployment, together with the suspension of elective services, kept essential front line services functioning. For example, the hospital was, throughout the pandemic, able to provide respiratory and/or ICU support, for all those patients where it was clinically appropriate to do so.

Background

13. GGH, Carmarthen, is one of two acute hospitals situated in Carmarthenshire, the other being Prince Philip Hospital, Llanelli. GGH serves much of Carmarthenshire, most of the south of Ceredigion and some of east Pembrokeshire. Bronglais General Hospital serves Mid Wales and Ceredigion to the North and Withybush General Hospital serves Pembrokeshire to the West.

14. Although the largest hospital in the HB it is the oldest. Opened in 1949 (it was previously operating from Nissen Huts) it was the first district hospital in Wales established under the NHS Act. Whilst it has undergone some degree of modernisation, with structures being built on to the original core, it remains, at heart, outdated and not compatible with modern healthcare – with or without a pandemic.

15. Carmarthenshire has a population of around 188,000 identifying as predominantly white (97%). Carmarthen Town has a population of just over 9,000 with 92.6% identifying as white. GGH covers a much larger population as I have mentioned above.

16. Attracted to the region by its coastline and countryside the over 65 age group make up around 23% of the population. The interior is largely rural with an overall population density of 322 residents per km² (it is even lower in the more rural Ceredigion and Pembrokeshire at 40 and 76 respectively).

17. Of the remaining age groups around 16% of the population are between 0-15 years, and 58% between 16-64.

18. Carmarthen Town has a slightly higher ethnic mix with 3.7% Asian, 1% Black, 1.5% Mixed and 1.2% categorised as Other ethnic group.

19. In March 2020, GGH had around 388 in-patient beds spread across 15 wards and employed 3,355 staff. The staff included amongst others 385 medical/dental, 960 registered nurses/midwives, 647 Healthcare workers and 395 in estates/ancillary services (268 domestics/cleaners).

20. GGH is a 'typical' busy district general hospital providing 24-hour Accident and Emergency care and acute services in both medicine and surgery, including trauma and orthopaedics, for all ages.

21. 13 of the wards are for adults and these include a 20-bed Stroke Ward, 14 bed Coronary Care Unit, 21 bedded unit for Care of the Elderly alongside general surgical and medical wards, including a dedicated respiratory facility (Padarn Ward). There is also a 10 bedded Mental Health Unit.

22. Cilgerran Ward has 25 beds for children with a 3 bedded Paediatric High Dependency Unit serving the entire HB region.

23. There is a Maternity Ward of 42 beds (28 labour; 14 ante-natal), Midwifery led Unit with 5 cubicles and an 8 bedded Special Care Baby Unit.

24. A relatively modern Intensive Care Unit (ICU) physically has 18 beds, although is currently funded for only 11 Level 3 beds with 1:1 nursing care. As the Health Board's largest ICU it tends to accept patients, when appropriate, from the HB's other acute sites rather than transfer patients out.

25. There are operating theatres supporting the surgical services, a separate Day Surgery Unit and facilities for renal dialysis.

26. Whilst there are acute services for the treatment of stroke and heart disease, vascular and neurological emergencies requiring surgical intervention are transferred to tertiary centres in Swansea and Cardiff.

27. Alongside in-patient care operate a wide range of out-patient clinics sometimes staffed by visiting consultants from other Health Boards (eg Burns/Plastics – Swansea Bay UHB). There is a Diagnostic Imaging Centre, including endoscopy, and an Oncology and Chemotherapy Day Unit linked to the main hospital.

28. Supporting all of this are pathology and microbiology labs, research and education facilities.

Staffing Capacity

29. Staff recruitment was an issue prior to the pandemic with long standing shortages of registered nurses being a particular problem.

30. This shortage was inevitably compounded during the pandemic by Covid related sickness, the need to self-isolate and staff shielding. Staff sickness rates, as the pandemic progressed, effectively doubled and were the single biggest issue affecting staffing capacity.

31. The fact that all Health Boards were in a similar position, and looking to recruit staff at the same time, exacerbated the problem.

32. The organisational response to the pandemic, with the development of additional clinical services such as Track and Trace/Vaccination, the separation of staffing teams for Red and Green hospital zones, the need for enhanced cleaning services, the additional time required for staff training and the creation of field hospitals stressed an already difficult staffing environment.

33. From 18th March 2020, Covid-19 diagnostic testing was available for all symptomatic staff and introduced, on a phased basis, for all staff groups (asymptomatic screening with LFDs) from early 2021. Whilst testing was welcome in terms of limiting viral spread and reassuring staff, it did exacerbate staffing issues by leading to self-isolation in Covid positive asymptomatic individuals. I am unable to provide its quantitative impact as I do not believe any formal 'Impact Assessment' was ever carried out.

34. The creation of temporary registers for retired doctors and nurses provided the HB area with 78 professionals, 14 of whom were based at GGH. These staff were recruited, almost exclusively, into such non-patient facing roles as PCR testing, so offsetting the impact on frontline staff although the overall figures for GGH were modest.

35. Prior to the pandemic, GGH would mitigate and/or fill staff shortages by recruiting registered nurses through local agencies and Health Care Support Workers (HCSWs) via its Hospital Bank. During the first pandemic wave the pool of available Agency Staff dropped. Between January 2020 and May 2020, the additional 'utilised hours' for bank and agency staff declined from 197.39 to 119.70. Those temporary

nursing staff still willing to work also tended to be less flexible and reluctant to do so in Covid endemic areas.

36. The measures adopted to address these staff shortages were taken at Health Board level and were essentially a combination of:

    a. A large scale recruitment campaign;

    b. A change in the approach to nursing;

    c. The re-deployment of staff.

37. The recruitment drive commenced in March 2020 and focused on HCSWs and Facilities Staff (i.e. Porters, Catering Assistants, Domestic Assistants, Laundry and Semi-Skilled). This was particularly successful and resulted in the creation of around 1,100 new staff providing the wrap around support needed for the registered nurses and the domestics required to carry out enhanced cleaning. The greater share of these workers would have been deployed at GGH.

38. Part of that recruitment campaign was the further development of the Healthcare Apprenticeship Scheme which had been introduced by the Board in 2019 to provide entry into nursing for those without qualifications in higher education. The scheme was initially adversely affected by the pandemic, with numbers dropping in 2020, but in 2021 achieved record levels of recruitment and, along with those retired professionals, was important in the staffing of Testing and Mass Vaccination centres.

39. This recruitment drive led to an overall increase in staff particularly in nurses and ACS (Additional Clinical Services staff) illustrated by the WTE figures for the relevant periods which I attach to this statement. To these figures should be added the 'Covid Cohort' of HCSWs recruited by the HB workforce drive. **[PK-001 – INQ000466547]**

40. The change in the 'standard' model for nursing followed on from national guidance issued by the Chief Nursing Officer (CNO) by letter dated 24th March 2020. It supported a relaxation of professional standards of nursing from fixed ratios of care; for example, in High Dependency Unit (HDU), 1 registered nurse to 2 patients, to a more flexible working model based on a team approach. The HB adopted and expanded this guidance in the development of its own policy and, with the upskilling of HCSWs providing 'wrap-around' care, registered nurses would oversee the care of a greater number of patients than previously calculated under the Nurse Staffing Levels (Wales) Act 2016.

41. Re-deployment included out-patient nursing staff moving to in-patient care. Nursing administrators returning to frontline nursing. The 'nursing' skills of allied healthcare workers – for example, physiotherapists and occupational therapists – were utilised. HB data supports the re-deployment of around 600 staff.

42. In tandem with re-deployment was the "on-boarding" of student nurses and medical students into paid clinical roles.

43. Redeployment, and mass recruitment, brought their own challenges. It was necessary to streamline staff induction processes and training. Whilst the hospital tried to match staff skills to re-deployed posts (for example, the intent would have been that out-patient/community nurses and physiotherapists with respiratory expertise would re-deploy to those wards where their skills were most useful) training staff for new skills was complicated by the requirement for social distancing and introduction of remote learning – itself an emerging tool few were familiar with.

44. Many staff rose to the challenge whilst some became anxious having to deal with new working environments and practices. In 2021 the HB, keen to understand the full range of the 'staff experience' and learn from those staff, commissioned and published a report on 'Understanding the Staff Experience in Hywel Dda Health Board during the Covid Pandemic'. I exhibit this Report to provide the Inquiry with a flavour of the issues and positive experiences created by re-deployment across the hospital sites. **[PK-002 – INQ000466548]**

45. No military were deployed at GGH and GGH staff were not generally provided to other hospitals. The initial modelling for field hospitals would have seriously stretched staffing resources. In practice the field hospitals established in Carmarthenshire were modest in comparison. Two became operational and provided step down care for non-covid patients transitioning from acute hospital care into the community. Whilst they provided important surge capacity, particularly during the second wave, absolute numbers were low – 263 (of which 133 were transferred from GGH) between 16th November 2020 and 5th June 2021.

46. Thus the staffing levels required for field hospitals were not significant and, in this Covid free environment, the hospital was able to utilise those staff who were shielding and not otherwise available for work.

47. Long Covid did not appear to be a significant factor affecting staffing capacity either at HB or hospital (GGH) level, although the data is probably not complete because a formal data set of staff absence due to Long Covid has not been kept.

48. In November 2021, the HB calculated that a total of 23 staff members were off work due to Covid related illness and, in its subsequent Long Covid Report in January 2023, the HB had identified a total of 63 staff members suffering from Long Covid though not necessarily absent from work.

49. Between November 2020 and October 2022, GGH have identified less than 10 members of staff on long term sick leave, absent for more than four weeks, with a Covid related illness. Of those identified, the majority have now returned to work. These figures can only be indicative of sickness due to Long Covid as precise data has not been collated.

50. GGH experienced one staff death attributable to Covid which was acquired within the community and not whilst at work. This occurred in April 2021 amongst a member of the portering staff. Whilst this was upsetting for everyone concerned, GGH was fortunate in that only one staff member died from Covid throughout this period.

51. Neither the HB or the hospital collected or recorded staff vaccination rates. Such data was collected nationally and is available through the Wales Immunisation System. Health care workers the Board were responsible for had vaccination rates for the first and second vaccines of 89.9% and 88.4% respectively.

52. Whilst all staff were strongly encouraged to take up the vaccine, particularly those working in high risk areas, vaccine uptake remained an individual choice. In the very early stages of the programme there were 'conversations' about compulsory vaccination but our understanding, certainly at HB level, was that such a policy would probably be unlawful and the Board were mindful that some staff were concerned and anxious about vaccination.

53. Generally healthcare staff were supportive of the vaccination programme, and as an organisation, the HB and hospital preferred to use education and flexible appointment times to maximise vaccine uptake.

54. The workforce measures set out were key to the maintenance of essential frontline services and, for GGH, largely effective although during the second wave of the pandemic (the winter of 2020/21) staffing levels reached critical levels. On occasions, with insufficient staff to support CPAP patients on Padarn Ward, patients would be unnecessarily moved to ICU for their ongoing care.

55. The changes made, particularly to the revised model for nursing in combination with HSCW recruitment and redeployment, enabled the maintenance of care in those

areas of greatest need. ICU remained operational throughout with the maintenance of 1:1 nursing care for Level 3 patients (those being ventilated).

Bed Capacity

56. The HB recognised the need to increase bed capacity, medical equipment and supplies prior to the WG's issuing of formal Covid-19 Hospital Discharge Service Requirements in April 2020. A HB level dedicated hospital discharge rapid response service issued guidance for all acute hospitals within the HB and this included the suspension of non-urgent surgical admissions and procedures, the identification of patients needing social care, rather than medical, their discharge from the acute care sector and the assessment of those patients waiting for admission to care homes.

57. The effect of these measures, in combination with a general reluctance on the part of the public to attend hospital in order to seek medical care, greatly increased hospital bed capacity.

58. At GGH the hospital's bed occupancy figures on 1st March 2020 for general wards and ICU were 348 and 11 respectively. Not at, but close to, full capacity. By 1st May 2020 these figures were 182 and 7 respectively and remained, at these relatively low occupancy rates, over the following months.

59. The ICU facility is an 18 bed unit with one fully functioning isolation room and three side rooms. In practice, and prior to the pandemic, it was funded for up to 11 Level 3 fully staffed beds – the number of available staff with the necessary expertise being the limiting factor.

60. In the early days of the pandemic modelling data suggested that the ICU facility would probably be overwhelmed. At HB level an Ethics Panel was established at the start of the pandemic and there were ethical discussions about the difficult decisions that may have to be made around care in such circumstances. **[PK-003 – INQ000466549]**

61. The HB was able to support an increase in ICU capacity for up to 16 Level 3 fully staffed beds with further HB escalation plans, largely involving the re-configuration of nursing staff, for additional ICU/HDU beds if needed.

62. In the event the projected demand for ICU beds, based on the initial modelling, did not materialise although there were periods during and following the second wave, relatively short lived, when the number of ICU beds required exceeded the physical space available within the Unit. The hospital responded by recruiting further Agency

staff, cancelling surgical lists and creating temporary ICU beds within the Recovery Bays of the Operating Theatres. In doing so, GGH did not reach the position where an ICU bed, if required, could not be found for a patient or when 1:1 nursing care for Level 3 patients could not be maintained.

63. GGH was part of the Critical Care Network (CCN) within Wales which met daily and also linked into UK level meetings. There were occasions when ICU patients were transferred to another hospital but these were transfers either for the 'escalation of care', usually to English hospitals, or for repatriation, and not because of concerns over capacity at GGH. This was settled practice before, during and after Covid.

64. The figures obtained through the CCN demonstrate that 22 patients were transferred out to another ICU and 63 patients transferred in from other HB hospitals (37), Welsh hospitals outside the region (22) and from outside Wales (4).

65. The reasons GGH was able to maintain frontline, in particular ICU, services were probably two fold.

66. Firstly because of its location, the first pandemic wave took time to reach West Wales, and GGH was never exposed to the level of clinical problems experienced by many English hospitals and those hospitals in East Wales closer to the border.

67. Secondly clinicians quickly learned from this initial Covid experience that ventilating patients, particularly older patients with co-morbidity, was not the best treatment when respiratory support was required and that less invasive modes, such as CPAP, were more efficacious. These patients were primarily treated on the respiratory ward (Padarn Ward not ICU) and clinicians became adept at accurately risk assessing those Covid patients who would benefit from ICU care and those who would not.

68. Thus by the time of the second wave the focus had moved from invasive to non-invasive ventilation and ward based management.

69. During the pandemic medical equipment and supplies were sourced either centrally through UK and/or WG procurement services or directly by the HB. For example, in March 2020, in anticipation of requiring at least an additional 192 ventilators, the Board sought 142 through NHS Wales' procurement services, and additional ventilators directly from Drager a global device manufacturer. Hospitals within the HB, such as GGH, had no independent means of purchasing and/or securing such equipment.

70. It soon became apparent that the HB's initial request for ventilators, the majority of which would have been used at GGH, would not be met due to global constraints on supply. Around 50 machines were obtained when Drager were able to recycle machines, some of which had been removed from service but retained by the HB. NHS Wales, through the Department of Health (DoH), could only offer machines that the HB were unable to safely deploy due to unfamiliarity with the model and no means of servicing.

71. Fortunately, the anticipated need for ventilators did not arise.

72. At GGH the mainstay of respiratory treatment for Covid patients was non-invasive ventilation - CPAP. The supply of these machines, sourced both nationally through NHS Wales procurement and directly by the HB, was never an issue. By late Spring 2020 the HB had around 1,000 CPAP machines available and, because not all of the machines could be used, donations were made to other HBs – in this case 200 CPAPs donated to Aneurin Bevan UHB.

73. The constraining issue on ventilatory capacity, aside from staffing levels, was a structural one nowhere more acute than at GGH. It was soon apparent that the supply of oxygen, the volumetric flow rate, and not the volumetric reserves, would be insufficient to meet the anticipated net oxygen demand arising from both ventilator and CPAP modes of treatment. There was simply insufficient on site capacity to convert liquid oxygen into gas at a quick enough rate to meet anticipated demand.

74. The HB pursued additional bulk oxygen capacity through national procurement and directly with BOC. Ideally, the installation of an additional evaporator plant (VIE or Vacuum Insulated Evaporator) at GGH was required but this was not achieved until December 2021. In the interim, in April 2020, BOC replaced the existing oxygen vaporizer and, over the following months, an extensive maintenance and repair programme, as well as systems upgrades to improve fluid transfer efficiency, was undertaken in order to increase flow where possible, reduce leakage and maintain oxygen flow rates and pressures in the distal part of an ageing circuit.

75. I am not aware of any issues with regard to renal replacement therapy machines.

76. End of life drugs, medicines used in ICU and haemofiltration fluids were allocated and distributed through an agreed process between the DoH and the four nations. There then existed a collaborative approach within Wales ("mutual aid") designed to divert stock/resources to those in greatest need which was replicated at HB level through the Lead Pharmacist controlling supply to individual hospitals.

77. The supply of such drugs/fluids was not an issue at GGH although it was for other HBs. During the first wave, early 2020, there were requests from a HB in Eastern Wales for supplies which included infusion pumps, syringe drivers and dialysis fluid and GGH was able to assist.

78. Given the surge in testing there was predictable pressure on blood supply tubes and ancillary resources. Measures were taken by GGH to ensure existing stock was maximised by reducing wastage and changing the clinical threshold for tests.

79. In West Wales, the private healthcare sector is limited to a single hospital in Carmarthenshire. The BMI Werndale is a small 20 bed hospital with two operating theatres and three recovery bays. There is no ICU or HDU and complex surgery is not carried out.

80. During Covid, the HB's direct engagement with Werndale was initially subsumed within the All Wales commissioning arrangement negotiated through the Welsh Health Specialised Services Committee (WHSSC) (comprising all HB Chief Executives) and funded over a 14 week period by WG. When that agreement ended direct commissioning, and funding, by the HB was resumed. GGH did not, independently of the HB, source private care.

81. The use of the private sector had no real effect on staffing capacity or the supply of medical equipment. Modest use was made of Werndale's diagnostic services (the hospital has a static MRI and mobile CT scanner) and the hospital was established as a non-covid hub. Out-patient care in gynaecology, urology, ENT, ophthalmology and urgent colorectal cancer was, in part, relocated there. General surgical sessions and in-patient support for gynaecology, urology, ENT and breast cancer was carried out and, from August 2020, elective orthopaedic work commenced. Staff and in some cases medical equipment travelled to Werndale with the patients.

82. Whilst Werndale was able to provide some support and assistance in the management of non-covid conditions its limited capacity meant that it was only a break on demand and waiting lists.

83. Further outsourcing to private providers took place in 2021/22, including ophthalmology to Community Health and Eyecare Ltd; trauma and orthopaedics to BMI hospitals in Droitwich and Bath; the Spire, Bristol; St Josephs, Newport; general surgery and urology, Sancta Maria. The sourcing of the private sector, which continues to this day, was both necessary but not sufficient.

Infection, Prevention and Control

84. The HB's IPC Team consisted of a central 'policy' hub (the IPC Cell), which received and assimilated national guidance, both UK and Welsh, and hospital site based operatives who are part of the HB wide IPC team.

85. National guidance was followed but at hospital level interpreted more purposively than literally. The planning and implementation of patient streaming, isolation and screening needed to be adapted to the design and nature of the hospital building.

86. The Board's Infection Prevention (IP) teams joined daily virtual meetings ensuring the rapid transfer of information from 'policy' to 'operational'.

87. At GGH the operational team was very active and would disseminate all relevant guidance and changes through regular 'patient flow' meetings and global and group emails involving all senior nurses and ward sisters. An IP Nurse was on site seven days a week, rotating round the four acute hospital sites each weekend, and they would physically circulate information to the relevant areas. This IP nurse was available via bleep and phone for support and actively involved in explaining guidance and disseminating PPE training for all wards and departments.

88. This was supplemented by information placed on the intranet (posters, FAQs and links to current guidance), signage on doors and corridors and the creative use of videos ("donning and doffing of PPE"). Regular Team meetings were also held with representative of services who had their own unique site challenges – for example, Mental Health and Acute Care.

89. There were problems with some of the national guidance.

90. The hospital, and HB, had to respond to IPC challenges in real time and guidance often followed on from operational changes already made.

91. The frequent changing of guidance, particularly during the pandemic onset, caused obvious practical problems but also staff confusion and anxiety.

92. Guidance could be inconsistent. Early in the pandemic national guidance (UK/Wales) contradicted professional guidance (UK Resuscitation Council) on the use of FFP3 masks during CPR. This was not an isolated incident.

93. A problem in Wales was that Public Health England (PHE) guidance was usually announced on a Thursday, but guidance from Public Health Wales (PHW) the following afternoon (Friday). This caused an unnecessary level of anxiety for staff

aware, through the media, of the PHE 'Thursday guidance' but unsure whether or not these changes would be effective in Wales until following day. From an operational perspective the changes could be implemented over the weekend but if the guidance needed adapting to the building it was often too late to discuss such changes with all relevant colleagues. It also built in a further delay to the production of posters, signage, videos etc necessary for effective dissemination across the organisation.

94. The HB soon learnt that the WG tended to track any PHE changes and used the 24 hour 'delay' to source and ensure the availability of any 'stock' such as new or increased levels of PPE.

95. The practical problems in implementing IPC guidance lay in the hospital's infrastructure:

    a. Most of the wards and corridors were without air conditioning/filtration systems; windows which did open did so to a limited extent and maintaining air flow and safe oxygen levels was difficult;

    b. Corridors were narrow and ward space limited; in order to achieve adequate social distancing, ideally half the bed stock within bays should have been removed; as this loss of bed capacity was not an option Perspex screens were erected between beds which, in turn, impacted on physical access to patients (particularly in an emergency), air flow, the use of manual handling equipment and oxygen supplies;

    c. The wards had been originally designed with limited side rooms, inadequate in number during infection outbreaks, shared washing facilities and communal ward hand basins too close to patients;

    d. There was a general lack of space for staff, particularly medical and nursing, and the staff rest rooms that existed were too small for 'social distancing';

    e. Access to parts of the building could only be achieved down a single, narrow corridor – for example, the entry to x-ray/radiography;

    f. The interlinking of ward bays obstructed efficient patient 'zoning'.

96. Poor ventilation was not only an infection control issue it presented a serious fire risk from elevated concentration levels of oxygen in internal spaces where the prevalence of intensive oxygen therapy (CPAP and cannulated nasal oxygen) was high. The HB invested in portable oxygen monitors which were then placed on the hospital wards alerting staff to the need to take local measures, opening of windows and/or re-

spacing of CPAP machines, when oxygen levels rose to potentially hazardous levels. The opening of windows, particularly in the winter, was not very efficient and exposed unwell patients to the cold. Opening of doors potentially increased the risk of Covid aerosol spread. Eventually, portable air exchange units were purchased and placed on the wards in the hope of mitigating this problem.

97. The lack of staff space was in part off set by the use of 'spare' areas such as seminar rooms and a patient gym. Outdoor areas were created but in winter were not popular. The doctors' accommodation was a significant concern being an 'out-dated' shared area for up to 20 junior doctors. Separate accommodation was found by moving them into local B&Bs, pubs with rooms and student facilities.

98. As far as possible, wards were re-configured into Covid (Red) and non-covid (Green) areas and the hospital into Red and Green pathways. However, on occasion, when Covid positive patients were identified in a Green area, the patient would be moved to a Red area, but also this sometimes led to the Green area being re-designated as Red. The cohorting of patients, with the segregation of nursing staff, provided added pressure on nursing capacity.

99. To mitigate the hospital design, certain wards were re-located. Padarn Ward (respiratory) was moved above ICU with a dedicated route and lift for Covid patients being moved from A&E to ICU.

100. The HB followed national guidance in testing for Covid and then ensured this was 'rolled out' across all four hospital sites, including GGH.

101. For the purposes of infection control and/or screening PCR testing of returning symptomatic holiday makers from designated countries commenced in January 2020. PHW would notify the Board who then notified the relevant IPC team of those travellers within GGH's locality who needed such tests. The samples were collected and returned to the PHW laboratory which was, I believe, initially in Cardiff, for processing.

102. On 18th March 2020, the hospital introduced PCR testing of all symptomatic patients and staff, including asymptomatic staff with a 'positive' household member.

103. Toward the end of April 2020, in line with national guidance, all patients being discharged into care homes were tested and by August 2020, again following national guidance, all pre-operative/pre-procedure patients (e.g. oncology patients). The latter was a response to the resumption of elective surgical activity and, in part,

the emerging evidence that Covid positive patients were an anaesthetic 'high risk' group.

104. In November 2020, as the second Covid wave had begun, all patients being admitted to hospital were tested and, later that year, GGH introduced point of care testing (POCT) on arrival at A&E.

105. In late November 2020, with the introduction of LFDs, WG recommended the commencement, by 14th December 2020, of twice weekly testing of all patient facing staff as a screening measure for Covid-19.

106. At the time of this announcement there were no secure supply lines, or reporting system, in place for the delivery and processing of LFDs. There were also concerns about LFD's sensitivity and specificity. The second wave of Covid was rapidly accelerating and staffing issues were to the fore. Accordingly, the HB's Executive Team took a considered decision not to introduce immediate general staff screening, which have would have involved around 9,000 HB staff plus primary workers, but a phased approach whilst the reporting system for LFDs was fully digitalised. There was an added concern that the manual inputting of data, then necessary for LFD processing, would divert resources from the vaccination programme, then a HB priority, and any false positives generated by the testing programme, an unknown, would further stress an already depleted workforce.

107. On 27th January 2021, the Board approved a phased testing of all patient facing asymptomatic staff and the 'roll out' was commenced on 1st February 2021 with chemotherapy staff, 80 in total, in February 2021. This was then extended over the following months as the system became more robust and completed by the end of July 2021. For practical/staff resource reasons patients and staff were tested every fifth day, broadly in line with the recommended 'twice weekly' testing.

108. When LFD testing was introduced robust supply lines were not in place and this affected the introduction and roll out of LFD testing in its early stages. Other than this 'temporary' issue GGH did not suffer from testing kits and/or supply shortages.

109. PCR samples were initially sent to a PHW laboratory in Cardiff and then in addition, as demand increased, through a UK portal to UK Lighthouse Laboratories (LHL). These laboratories processed most of the community work and testing of HB staff. On site testing at GGH was more efficient in terms of turn-around times but limited in its capacity.

110. Delays in reporting, particularly when samples were being dealt with by LHL, were not uncommon and most noticeable during the second wave of the pandemic as demand increased. If a sample was known to be important, for example a member of the ICU team, it was directed and processed internally by GGH (or any available HB laboratory) where delays were minimal. Possible adverse consequences were also mitigated by patients and/or staff being managed as covid positive until the test result became available.

111. Whilst I am not aware that any reporting delays directly led to onward transmission of the virus, in my view it is likely they would have done so even if, in the interim, the patient was nursed as Covid positive until proven otherwise. Delays would also have influenced decision making and patient flows, in particular delaying transfers to Green wards or discharge from hospital.

112. Whilst the introduction in January 2021 of widespread LFD screening was phased and for practical and operational reasons not in accordance with WG's suggested time line, it was aligned with the principles expressed in that policy as were all of the operational measures for testing set out within this statement.

113. GGH suffered a series of nosocomial outbreaks during the second wave between October 2020 and January 2021.

114. HB infection outbreak management policies, adopted by the hospital, pre-dated the Covid pandemic. During the pandemic the hospital followed UK Covid-19 Outbreak Guidance and, more specifically, the WG's '16 Point' Outbreak Plan for Wales. In addition, and through the HB, the hospital had its own Outbreak Control Team (OCT) which, with expert assistance, decided on the best way of implementing guidance locally.

115. Outbreak responses were carried out at hospital level through Outbreak Meetings and a copy of one of these multi-disciplinary meetings is provided. **[PK-004 – INQ000466550]**

116. At GGH, in relation to these outbreaks, it was felt more vigilance was required surrounding IPC and the use of PPE given that the first wave of Covid had been managed and contained without any ward outbreaks. Although, it has to be remembered that Covid incidence was rapidly increasing in the community, the disease was highly infectious and many individuals were infectious but asymptomatic.

117. Outbreak measures therefore focused on the re-enforcement of the high standards needed around the use of PPE and the enhancement of cleaning services with UV cleaning being employed, and an acknowledgement that the roll out of Covid screening, including 'Point of Care' testing, would be an important adjunct to outbreak control.

Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE)

118. PPE and RPE stock was held centrally in NHS Wales supplies (NWSSP) and then distributed to individual Health Boards according to anticipated need.

119. Within the HB stock was held on sites throughout the region with each hospital having its own 'hub' for stock. Dedicated storage space was created within the 'Cambrian Room' at GGH.

120. The hospital ordered PPE and RPE directly from Health Board supplies as and when needed. There was a general policy in place not to allow stock to fall below two weeks' worth of anticipated supply and lines of supply were monitored daily. In practice the system worked well and was sufficiently flexible to allow for ad hoc emergency orders and movement of stock between hubs within the HB according to need.

121. GGH did not source equipment directly from other Health Boards, but there was a policy of mutual aid between individual HBs and between HBs and Local Authorities.

122. Early in the pandemic, when it became apparent that national supplies would probably be unable to meet anticipated demand, HB procurement teams (through the PPE cell) purchased equipment locally from non NHS suppliers. This included items such as powered hoods, hand sanitisers, reusable gowns, small sized gloves and Perspex.

123. Although at the outset there existed considerable anxiety in relation to PPE stock levels, and the supply of face masks in the summer of 2020 did reach critical levels, at GGH generally supply was not an issue and neither were there any significant delays in obtaining equipment once ordered. The Emergency Request System was not used.

124. There were some issues over 'quality'.

125. Some face masks in use, particularly at the start of the pandemic, were technically expired with the original expiry date having been extended, on occasions more than once, by being re-stamped over the original expiry date. The hospital was assured

by NHS Wales Shared Services Partnership (NWSSP) that expiry extensions had been undertaken at national level after rigorous quality assurance testing.

126. In similar vein some face masks exported from China, apparently for reasons validating export of such equipment, were marked "not for medical use".

127. There were also more minor issues with face masks, such as poor quality straps and fibre shedding during use. These items were immediately removed from use.

128. Understandably, staff were anxious and required reassurance.

129. Early in the pandemic there was a shortage of FFP3 masks as the '3M 8833' was the commonest design but also one of the largest face pieces on the market. This led to a high failure rate in fit testing amongst small faced staff workers. This resulted in staff involved in crucial patient facing roles being fitted with the more expensive Powered Air Purifying Respirators (Powered Hoods) and other staff being redeployed in non-covid areas until smaller masks were available.

130. Faulty batches of face masks did occur and were identified, marked and returned to central stores.

131. The main problem with the FFP3 face mask was the inconsistency in manufacture. Producers changed frequently and staff would pass the 'fit test' for one FFP3 type and then fail another. Maintaining the Fit Testing programme became resource hungry. This was less of an issue for staff working on one ward, where appropriate masks could be stored, but more of a problem for members of cardiac arrest teams where the masks available on arrest trolleys would vary from ward to ward. Members of arrest teams were therefore encouraged to carry their own 'fitted' masks with them but this was not always possible.

132. ICU and theatre staff resolved this issue by wearing PAPR (the Hood and Belt type respirator masks).

133. One type of FFP3 mask was designed with a one-way valve which protected the wearer but not the patient from the wearer. Some single use aprons were flimsy and became easily damaged. Generally, staff worked with the PPE provided and, given the unique circumstances affecting global demand and supply, it was understandable that there would be inconsistencies in product quality.

134. Fit testing had been introduced at GGH prior to the pandemic as part of the hospital's infection outbreak measures focused at the time on influenza and similar viruses. It was then a smaller programme focused on key areas such as ICU, A&E and

respiratory wards and based on a qualitative method of testing which involved using the mask wearer's sense of taste to check the fit.

135. When, in early January 2020, the HB became aware of the emerging Covid situation in China, a Fit Testing Procedure was established in order to ascertain the 'fit test' status of all hospital staff and the programme in place extended, with further training and recruitment of, in total, 575 'fit testers'.

136. GGH rolled its programme of qualitative fit testing out to all wards deploying a total of 185 trained fit testers with some 'Champion Fit Testers' given dedicated time to concentrate solely on this role.

137. The supply of fit test solution did cause problems with occasional shortages of either the bitter or sweet solutions but fortunately never both simultaneously. The hospital never completely ran out of stock.

138. A small number of staff repeatedly failed their fit testing. This was a particular problem amongst men with beards as a seal of the mask could not be obtained. As an alternative they were provided with PARP.

139. There were no interruptions to the fit testing programme at GGH but it was a time consuming process with the main stress on fit testing resulting from the previously described frequent changing of FFP3 masks with multiple types in use.

140. In summary, although there was considerable anxiety at the start of the pandemic, the hospital was able to work around any issues over PPE supply. There were problems with some of the products delivered but these were more logistical issues than ones of safety and, in the circumstances, staff worked reasonably well with the equipment supplied.

Visiting Restrictions

141. Throughout this period visiting policy was decided at HB level and discussed and actioned through regular meetings between, largely, senior nursing staff at GGH and the Executive Directors. In line with such policy, restricted visiting had been introduced prior to the cessation of visiting announced by WG on 25th March 2020. Those prior restrictions limited the number of visitors, the duration of visits and excluded children.

142. Following the WG's announcement, all visiting at GGH ceased immediately, save for allowances being made to facilitate the visiting of one parent/guardian at a time visiting their child, a birthing partner and patients receiving end of life/palliative care.

143. Those 'exceptions' were later extended (August 2020) to include women and their partners when undergoing their scheduled 20-week anomaly scan

144. In around April 2020, following an update from the CNO dated 20th April 2020, and as it became apparent there was an additional requirement to support those patients impacted through either cognitive impairment, learning disability or specific clinical needs, these exceptions were extended to provide for such individual patients. This would have included patients with learning disabilities/autism or dementia where the absence of visiting was causing patient distress.

145. This general discretion, vested in the ward sister (or nurse in charge), was directed at allowing visiting when in the patient's best interests. It was intended to provide some flexibility to the general restrictions in place when a clear 'best interests' reason could be identified. Nursing staff in charge were encouraged to consult with the IP teams when there was any doubt or concern about allowing visiting.

146. That discretionary 'best interests' policy was later reflected in the national guidance on 'purposive visiting' issued by the CNO in July 2020, which was itself a product of the regular meetings held at national level between the nursing heads of all HBs.

147. The formal written HB in-patient visiting policies, which pre-existed Covid, were amended in April and June 2020. It was not until February 2021 that a written 'interim' Covid in-patient policy was approved. That document set out the approach to visiting already in place. Although there was no formal stand-alone policy for patients with communication difficulties and/or cognitive impairments the 'best interests' approach, in practice and articulated within the written policy document, was developed with these patient groups very much in mind. The relevant policies are provided with this statement. **[PK-005 – INQ000466552, PK-006 – INQ000466553, PK007 – INQ000466554]**

148. On the ground, the approach to visiting had to respond to a dynamic situation which reflected local conditions whether that be outbreaks within the hospital or the prevailing infection rate in the community. The temporary suspension of visiting was not uncommon either within parts of GGH or at hospital level.

149. It is also fair to say that in the early days of the pandemic, when there was probably greater anxiety about Covid and the efficacy of PPE and Covid treatments, there was understandable concern on the part of nursing staff to allow visiting save in the most exceptional circumstances. The move to a more purposive approach probably took

time as staff gained more confidence in managing Covid and the procedures around the infection.

150. In around May 2021, with the prevalence of Covid-19 being very low amongst hospital in-patients, visiting restrictions were further eased and a booking system introduced to enable family and friends to visit in a structured way which would maintain social distancing. GGH was the first hospital within the HB to introduce booking.

151. In October 2021, following a Covid-19 outbreak at GGH believed to be related to seeding by asymptomatic visitors despite LFD testing being required and the scheduling of appointments, all non-essential visiting was suspended until November 2021 when the booking system was re-introduced.

152. Patient visiting has always been an important part of healthcare and it was recognised, from the outset, that contact with family and friends needed to be supported. A range of measures to facilitate such contact were put in place.

153. From April 2020 all acute wards were provided with 2 iPads and the establishment of an online communication form with a dedicated email address allowed messages to be sent, including photographs, which were printed off and delivered to patients. Smart phones were purchased and distributed to wards to enable patients without such devices to use Skype and other mediums.

154. From June 2020, Family Liaison Officers (FLOs) were recruited largely from the hospitality and retail sectors. All wards at GGH had one FLO, some larger wards had two. FLOs were an essential, and personal, link between patients and relatives, supporting contact through video calls, voice calls, letters and/or emails. They would also help in the collection and drop off of patients belongings supplementing the 'Stop, Drop and Go' service co-ordinated by PALS. As importantly, FLOs developed close relationships with patients helping them at mealtimes and providing support both practically and emotionally.

155. Whilst, as stated, there was no specific policy for patients with communication difficulties, many of the staff are bilingual (Welsh and English) and supporting Welsh speaking patients was not an issue. A relatively high proportion of the staff (as compared with the local population) are ethnic and, in practice, language was seldom a barrier. If communication remained an issue each hospital ward had access to the Insight app which provided online access to interpreters including BSL interpreters via video link.

156. That said facilitating visiting for those patients with learning disabilities was challenging and the hospital did its best to enable families and carers to visit and support such patients.

157. It is obvious to state that the introduction of restricted visiting impacted negatively not only on patients but family members, loved ones and healthcare staff. Family visiting is well recognised as an invaluable resource in many direct (hands on) and indirect (morale boosting) ways. Its restriction was not taken lightly.

158. Whilst it was difficult to find the right balance for in-patient visiting the priority was to ensure the safety of patients and staff and of course to prevent the seeding of infection. The need for social distancing and lack of space within GGH did not facilitate visiting and any discretionary policy often introduces some inconsistency.

159. That said I believe that the right balance was probably struck with the hospital doing its best, through specific visiting arrangements supported with all necessary PPE, to allow relatives to visit loved ones at the end of their life. In addition the hospital encouraged and enabled virtual visiting and, through FLOs and PALS, tried to maintain that vital link between patients and their families.

Patient Treatment and Care

160. On 13th March 2020, WG issued a written statement which included the suspension of non-urgent services to prepare for the expected surge in Covid-19 cases. All non-urgent, elective work therefore ceased at GGH and it was not until June 2020 that re-introduction of such some work, phased, predominantly virtual and much reduced in capacity, took place.

161. There were many challenges to the continuation of non-covid work. Staff were re-deployed from these 'non-essential' services to cover staff sickness, shielding and general shortages within the urgent and frontline Covid services. The need for, and lack of, Green dedicated zones disrupted surgical activity at GGH. Social distancing complicated diagnostics, slowing down the process and reducing in person out-patient assessments.

162. Whilst Werndale Hospital was in a position to take over some of the general surgical activity, because it had no ICU/HDU facility, high acuity work needed to be carried out either at GGH or other acute sites across the HB.

163. By necessity treatment pathways for all non-covid work were radically transformed and the following examples in cardiology and colorectal work were replicated across the specialities.

164. In cardiology a service hotline was set up for waiting list patients who were contacted in perceived order of priority and assessed and reassured by members of the medical team. Clinics became entirely virtual with telephone platforms linked in to the medical data base. A consultant led 'up front' triage system reviewing all Out Patient (OP) referrals was developed. This led to the identification and increased use of community facilities – cardiac nurse and relevant investigations – prior to any OP appointment thereby greatly streamlining the service.

165. In addition, a remote, telephonic, pathway was developed for the testing of cardiac implantation devices with patients no longer being asked to attend hospital, as before the pandemic, for the downloading of such information.

166. These new pathways for cardiology have endured, and been further developed, beyond the pandemic with transformation of the service. Face to face waiting times for the most urgent cases have been reduced as have times from referral to patient review and amendment of medication. This has led on to reduced admissions into hospital for acute/acute on chronic heart failure.

167. In the management of colorectal cancer, urgent OP care was re-located to Werndale Hospital and was controlled by direct consultant oversight of all GP referrals. Suitable patients were directed 'straight to testing' rather than a telephone appointment and virtual consultations have replaced face-to-face consultations as the norm. Faecal Immunochemical Testing (FIT) a stool screening method, introduced on 8th June 2020 as part of the bowel cancer pathway, also reduced the need for formal in person appointments.

168. When elective surgery was re-introduced, colorectal cancer was prioritised and moved to Prince Philip Hospital, Llanelli, with patients operated upon by Carmarthenshire surgeons, where a dedicated Green area with a Green ICU/HDU was provided. The care pathway was modified, with patient consent, so that rectal cancer resections were routinely combined with a de-functioning ileostomy in order to reduce the severity of any anastomotic leak and decrease the number of repeat re-operations.

169. Elective hip replacements for Carmarthenshire were undertaken at Prince Philip Hospital, Llanelli and that continues to be the case, although there were periods

where orthopaedic cases were paused due initially to WG Guidance and then due to service pressures.

170. At the start of the pandemic, ambulance handover times significantly improved. On 29th March 2020, only 2% of all handovers were taking more than one hour. By December 2020 this had risen to over 51% of all handovers.

171. During the first few months of Covid, A&E attendances and the number of ambulance arrivals dropped which, in combination with the general availability of beds, reduced ambulance waiting times.

172. However by the time of the second wave, A&E attendances had risen and the hospital was operating at around capacity. It was difficult to discharge patients from hospital, particularly into care homes due to the prevalence of Covid and the lack of available care home beds. The hospital was also treating a higher proportion of frail, elderly patients with increased morbidities who needed longer hospital stays and there were few, if any, community options for those in patients who were covid positive.

173. In respect of those individual patients waiting to go home, GGH doubled its efforts with the relevant Local Authority teams and community in order to provide the support needed to facilitate their discharge. This proved a difficult and intractable problem and which has persisted beyond the immediate aftermath of Covid.

174. Early on in the pandemic, it was evident to clinicians that new pathways needed to be developed for the management of patients with Covid and any treatment escalation. It became important to risk assess these patients early and avoid resuscitation in situations where the risk assessment deemed it to be futile. This also then avoided unnecessary risk to staff from uncontrolled resuscitation and intubation.

175. The document provided, titled Covid-19 Intubation Procedure (19th March 2020), was authored by two ICU trainees and based on understanding at the time. It was available to all admitting teams and was a local clinical pathway for patients with Covid which was updated as new evidence became available in infection management; for example, the use of steroids and anti-virals. Escalation decisions to ICU were made by ICU and respiratory consultants jointly and in discussion with patients and/or family. **[PK-008 – INQ000466555]**

176. Other over-arching HB guidelines were also produced as well as local policies; for example 'Guidelines for Type 1 Respiratory Failure Management for people with COVID' **[PK-009 – INQ000466556].** These local policies would reflect national

advice (including NICE guidance) and were used in conjunction with such guidance which, during this period, was frequently updated. The local policies provided local context and were used to help ensure that clinicians took everything into account when assessing patients, and also to support decision making. They were therefore central to the management of patients during the pandemic.

177. At GGH these 'guidelines' were supplemented by a Clinical Command Hub, unique to GGH (within the HB experience) which included a senior respiratory physician, senior nurse and junior doctor. This Hub reviewed and monitored the guidance and provided a link to doctors on the ward who required senior advice and support.

178. These treatment 'guidelines' were not viewed as tools to ration care, but a pathway for best medical practice as perceived at the time. It was welcomed by clinicians at GGH dealing with a new, emerging management problem, and it was viewed as a guide for clinicians to provide the best possible care safely. It was not seen to infringe any well-established ethical principles for providing care. There was no formal consultation with the HB's Ethics Panel.

179. Pre-pandemic the policy for admission to ICU was that a consultant to consultant referral and discussion should take place on an individual basis for every patient. In practice this did not always happen and, mindful that Covid-19 was a unique disease with high mortality in unwell elderly patients, the only change post pandemic was strict adherence to the principle that all potential admissions to ICU should be discussed between a respiratory consultant and one in intensive care.

180. This worked well and the co-operation between the two specialities was very good. Most of the patients were, in fact, managed on the respiratory ward with non-invasive ventilation. There were occasions when escalation of care to invasive ventilation was agreed, there were also occasions when ICU accepted patients with a ceiling of care in place where there was no capacity on the ward for continued non-invasive ventilation.

181. Neither did the criteria for providing oxygen therapy change. What clinicians learned was that unwell patients with Covid, particularly in the older age groups, did better with non-invasive ventilation (CPAP) than being escalated to invasive ventilatory support.

182. Whilst the rationing of care and clinical resources (oxygen, beds, ventilation and CPAP) was never made explicit, clinicians were aware from the outset of the "reasonable worse case scenarios" and that if these predictions were correct the

service could be overwhelmed. Thus clinicians understood the need to manage those resources carefully and take sensible, efficacious decisions.

183. In the event, the CPAP stock was sufficient and the oxygen upgraded and able to support the CPAP machines and ventilatory requirements of the hospital. The challenge in providing CPAP related to staffing levels and 'functional capacity' with staffing resources, particularly at the end of 2020/early 2021, being stretched to support patients who may require treatment with CPAP. However, I do not believe that at GGH it ever got to the point where 'equal' patients were competing for CPAP/Ventilatory support and I am not aware of any concerns being raised regarding 'rationing'.

184. DNACPR notices and/or advance care planning forms have been a recognised part of a patient's care for many years and the HB regularly issue and update guidance in this respect.

185. ReSPECT, a process developed by the Resuscitation Council has not been formally adopted by the HB or, as far as I am aware, any HB in Wales.

186. The HB guidance, which includes a video available as an aid to good practice, stresses the need for good communication with all interested parties and supplements the training and guidance clinicians and nurses receive through their own professional training and bodies. In particular, those staff regularly involved in resuscitation during their annual resuscitation training and updates.

187. Any DNACPR and/or advance care notice is always taken into account when providing treatment. Whether or not the patient had Covid would not affect clinical decision making prior to the need for resuscitation. It was, of course, recognised that seriously ill patients with Covid and multiple co-morbidities responded poorly to emergency intubation and CPR and posed a risk to health care providers. Therefore staff, to that end, and where it was clinically appropriate, were encouraged to consider and discuss such notices early in a patient's care.

188. Such notices form part of the patient's paper records. In Wales it is not currently possible to upload the forms so that they appear electronically. My understanding is that steps are being taken to enable incorporation of these notices into a patient's digital record.

189. In relation to the inappropriate issuing of DNACPR notices, I am aware that on 14th February 2021, the Health Board (not GGH) received an email from a local Learning and Support Assistant, concerned that DNACPR notices were being issued by HB

staff for Covid-19 patients with learning difficulties without their consent. I am aware of a formal complaint, on the same issue, relating to a HB patient (not GGH) which became the subject matter of a joint letter from the CMO Dr Atherton and the CNO Ms Sue Tranka to the HB's CEO on 14th April 2022.

190. I also note from the minutes of a HB Palliative Care End of Life meeting on 11th May 2021 that Name Redacted stated that she *"had received positive feedback from A&E Departments in Hywel Dda regarding the fact that they have seen an increased number of patients where DNACPR forms have been completed in the community/primary care and Advanced Care Planning and/or ceiling of treatment wishes have also been evident"*.

191. Dr Edmunds, Hospital Director, is aware of a patient incident from February 2021 when a junior doctor commenced the issuing of a DNACPR notice to a patient with a learning disability, on the grounds of 'poor quality of life' and was stopped by a member of the nursing staff. Following the unexpected death of the patient, an internal incident was raised and a 'Root Cause Analysis' carried out. The issue surrounding the attempted notice was the subject of further individual learning but not felt indicative of any widespread practice.

192. There have, over this period, been some complaints in relation to DNACPRs but Dr Edmunds is not aware of an increase in DNACPR notices which did not appear to be clinically appropriate, and nor is she aware, from her own experience, of an increase in the number of patients arriving at GGH with a notice on their notes.

193. The use of PPE, visitor restrictions and greater reliance on virtual communications for both visitors and services was problematic in two respects.

194. Firstly, face masks caused communication difficulties for the hard of hearing and deaf people reliant on lip reading. The HB tried, on a number of occasions, to source and supply clear face masks but this did not prove consistently possible with suppliers unable to create a viable product in sufficient numbers. Whilst a limited number were made available, priority groups, such as the Speech and Language Department and Mental Health Services, took precedence.

195. Secondly, a proportion of Hywel Dda's population were believed to be digitally excluded and whilst the use of telephone appointments did, to some extent, mitigate this problem, it remains a challenge for healthcare services more reliant on virtual services than before.

Impact on Hospital Staff

196. I have provided the Inquiry with a copy of the Board's published report detailing the staff experience during the pandemic. The psychological impact on staff cannot be underestimated and I simply refer the reader to that document. **[PK-002 – INQ000466548]**

197. The Health Board and hospital tried to support staff through its Staff Psychological Wellbeing Group which was set up with mental health clinicians, clinical psychologists as well as Workforce and Organisational Development staff. In parallel with this service was a staff wellbeing plan, adapted at each stage of the pandemic, which relied upon staff feedback to best support the group.

198. Ongoing surveys (for example the 'Your Well Being Matters' Survey of Nursing, Midwifery and HCSW staff) supplemented this support and the HB's own 'Staff Experience' survey was important in gaining their trust.

199. Within the hospital an on-site psychology and counselling team was available which provided a 'rapid response' service and was backed up virtually with access to webinars and on line counsellors. Staff also had access to a 24/7 telephone helpline run by an Employee Assistance Provider (Care First). Staff could be directed to programmes/courses proven to support mental well-being and manage stress or the counselling and/or psychological services available.

200. Experienced clinical psychologists were deployed to support the critical care teams. A dedicated clinical psychologist was based within ICU to support staff with issues of moral dilemma and trauma and additional psychological support was provided for 'high stress' Covid wards and A&E.

201. A key issue that emerged during the pandemic, and reported by the clinical psychologist I&S was the distress and upset that ICU staff experienced as a result of being unable to communicate with, and comfort, relatives face to face particularly when those relatives were excluded from a patient's bedside.

202. Bespoke support was offered to 'leaders' of teams and services and high grade nursing staff. A total of 90 'leaders' within GGH were offered this service with an uptake of 39. The aim was not only to support the 'leader' but help that individual provide compassionate support in turn to team members.

203. To ensure that staff were aware of these services, and that their work was recognised and valued, wellbeing support resource cards were sent to the home of every staff

member as was a bilingual "Supporting Mental Health & Wellbeing" manual and 'Thank You' cards. A monthly award was given to individuals and teams who were seen to be delivering services with compassion and fortitude.

204. At GGH creating physical safe spaces/well-being spaces away from the ward areas was very difficult and, in practice, not achieved. Staff break rooms on the ward were made more pleasant but given their size and the need for social distancing they could not be described as well-being spaces. Virtual common rooms were not something that GGH provided for staff. Perhaps these could have been given greater consideration.

205. Staff with Long Covid had access to the Long Covid Syndrome Service established in October 2021, which provided a multi-disciplinary rehabilitation programme for sufferers from this condition. Staff referrals would have been through Occupational Health (OH) or their own GP. In addition contractual sickness payments for Long Covid staff were extended with the possibility of applying for an 'Injury Allowance' and consideration given to bespoke phased returns to work.

206. From March 2020, it become apparent that certain groups were particularly vulnerable to Covid and the HB began to develop its own staff risk assessments in order to identify those potentially at risk on the basis of their health status and/or demographic and who therefore required re-deployment and/or shielding. This was introduced for the staff toward the end of March 2020.

207. On 22nd April 2020, the British Association of Physicians of Indian Origin wrote to all CEs of NHS Trusts (England) and Health Boards (Scotland and Wales) raising concerns about the high mortality rates for BAME individuals and the "palpable worry" that the matter was not being addressed with "sufficient urgency". This letter was representative of general concerns about this issue.

208. In the meantime, the HBs had been collaborating on a Risk Assessment Tool which was specifically designed to include BAME groups and, on 1st May 2020, WG forwarded the Aneurin Bevan UHB Risk Assessment to all HBs for their consideration. The Health Board's Silver Tactical Group, approved the use of this form, with some slight amendments, on 11th May 2020.

209. On 27th May 2020, WG officially launched the all-Wales Risk Assessment Tool and this was rolled out by the HB the following day and uniformly adopted across the organisation with all managers contacted to ensure they made all staff aware that the assessment tool needed to be completed. The only 'difficulty' with the Tool was

achieving full compliance and there remains a significant number of staff who have not completed the process.

210. Furthermore, and in part recognition of the disproportionate impact of Covid-19 on BAME staff, in June 2020 the HB established a BAME Advisory Group with the aim of providing a more supportive and protective environment within the workplace and strengthening communications between BAME staff and Executive Directors.

211. Although no impact assessment was carried out on the effect of carrying out staff Covid risk assessments, it is likely to have had some impact on staff capacity through shielding. Where possible staff were re-deployed. Shielding nurses/HCSWs helped staff 'Green' field hospitals or took up administrative roles.

212. Equality Impact Assessments (EqIAs) continued to be carried out on extant policies with pathways for such processes already embedded in those policies. New Covid policies, received by the HB from the UK and Welsh Governments, as well as the Royal Colleges, which required immediate implementation generally, did not have such assessments carried out, due to time pressure.

213. This approach to policies continued throughout the pandemic. Subsequently, where Covid policies have become incorporated within standard hospital policies, impact assessments will automatically be carried out as part of that policies review.

214. In relation to the unequal impact on staff of measures taken to manage the pandemic, the main issue, which also affected patients and visitors, was the widespread use of face masks. It was discomfiting even for those without hearing or learning issues. The hospital tried to source transparent face masks and a limited supply was trialled with staff. Unfortunately a consistent, safe supply of such masks was never achieved and it certainly impacted on the deaf/hard of hearing.

215. The Strategic Partnerships, Diversity and Inclusion Team was very much alive to this problem and delivered deaf awareness sessions for staff, running in May 2021, a deaf awareness week to promote understanding of these issues and support those with impaired hearing.

216. There was also a group of male staff who, for religious reasons, had beards and failed the 'fit test' for FFP3 face masks. This was an issue relatively easily resolved by providing individual powered hoods for these staff members.

217. Throughout the pandemic GGH had a close and effective working relationship with the HB. Meetings were regular with clear and open lines of communication.

Certainly at GGH those managerial staff felt that they were able to escalate matters to the HB, the HB was responsive and, in turn, provided clear directions to the hospital operational teams.

218. Within the hospital, meetings with managers and staff took place daily and team working was generally constructive with everyone doing their best to work together.

219. Feedback to national decision makers was at Health Board level not from GGH. As a member of the HB, and its current Interim Chief Executive, my view is that lines of communication, and responsiveness, was as good as could be expected in the very difficult circumstances everyone was working in. That includes UK and Welsh Government bodies.

220. The only point I would make, and it is a generalised one, is that I was often in receipt of a decision or communication on a Friday afternoon, which was obviously not helpful when further discussion with others, and subsequent implementation, was required.

221. National guidance was certainly not formulated with the physical constraints of GGH in mind but then guidance which is national cannot, in the time frames we were working with, reach that level of sophistication. The HB and GGH had to work with the lack of space, ventilation, single use rooms etc and adapt and do the best it could. These inherent problems within the system can only be resolved by dealing with hospital infrastructure, GGH probably being just one example of a UK hospital not, in the modern age, fit for purpose.

222. Did staff and management feel supported by national bodies, their Royal Colleges and PHW?

223. As a HB and hospital we worked closely, and I believe effectively, with PHW. They were regularly available not just at high level policy meetings but working with the teams in GGH, such as when outbreaks had occurred, providing much needed advice.

224. The Royal Colleges, as far as possible, were supportive particularly in providing professional advice and reassurance on professional standards during the pandemic and relevant information relating to Covid itself – both in terms of treatment and providing that treatment safely.

Hospital Specific Questions: Volunteers

225. There was a tremendous response from volunteers, including those furloughed and those past retirement age who wanted to give something back to their community. Many in this group were relatively high risk for Covid and/or needed to shield. They were therefore not placed in hospital sites unless these areas were Green or Amber and the majority were deployed in the community at vaccination sites.

226. When hospital wards, or areas, moved from Red to Green/Amber, the HB/hospital could have been quicker and more proactive in moving these volunteers back into the hospitals and as a hospital resource they were probably under-utilised. This would have been particularly relevant when furlough came to an end and there was a mass exit of volunteers back into work.

227. In the event of a future pandemic, it would be helpful to have a prepared All Wales Volunteer infrastructure in place. Much of the work has already been done and such a framework would include a:

    a. Clearly defined Risk Assessment process with an agreed Risk Tolerance level;

    b. Position on Volunteer Indemnity;

    c. Bank/pool of volunteers with reduced onboarding processes;

    d. Pre-existing set of health and safety learning packages/onboarding documents for volunteers;

    e. List of specific volunteering roles to direct potential volunteers in order streamline the process.

Recommendations

228. In my view the recommendations need to look at the existing infrastructure of hospitals in parallel with future pandemic planning.

229. At GGH, Infection Prevention and Control was compromised by the physical nature of the buildings, and all modern hospitals should be designed with pandemics and/or serious infection outbreaks in mind with existing buildings being upgraded.

230. Pandemic planning needs to develop resilience in staffing, medical equipment and supplies.

231. For example, there should be sufficient PPE stock, or local capacity to respond and supply such stock, built into the system. The development of 'reusable' PPE would change the landscape.

232. Investment in accurate/up to date statistical modelling taking into account the Covid experience would be beneficial.

233. The creation of a reserve workforce – both skilled and volunteer – would assist with staffing resilience.

234. The importance of national coordination of the senior clinical voice across Wales, to ensure rapid sharing of experience and learning.

235. Drawing on the experience of Covid, have pre-prepared Guidance developed from our learning, that could be rapidly adapted, disseminated and implemented.

236. Harness the learning from the rapid development of vaccines to be applied to future pandemics.

237. Share the learning internationally on the best ways of maintaining the well-being of clinical professionals in a high risk pandemic situation.

238. The development of surge capacity, whether through field hospitals or otherwise, should be decided nationally and funded centrally.

Statement of Truth

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

Signature Personal Data .....

Name: ..PHILIP.....KLOER

Dated: .....30/4/24.....