IN THE UK COVID-19 PUBLIC INQUIRY

BARONESS HEATHER HALLETT

IN THE MATTER OF: THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

CLOSING WRITTEN SUBMISSIONS ON BEHALF OF THE

GROUP OF WELSH NHS BODIES (GWHB)

COVID-19 INQUIRY: MODULE 3

Introduction

1. These submissions are made on behalf of the Group of Welsh Health Bodies (GWHB) at the close of the evidence of Module 3.[1] The GWHB comprises the majority of Welsh Local Health Boards and a Welsh NHS Trust in Wales and collectively, the Boards/Trust were responsible for primary and hospital care for the majority of the population in Wales. University Health Boards are given the acronym "UHB" below.

2. At the conclusion of his oral evidence to the Inquiry Vaughan Gething, Minister for Health and Social Services until May 2021, was asked by Counsel to the Inquiry ('CTI') if he had one recommendation for how to improve the healthcare system's response in Wales (beyond having more tests available at the beginning and more PPE in the stockpile) what would that be. He said:

   "I think you'd also have to just take out finance, because if you want to improve your estate, you have to spend lots of money on it. I actually think that I've covered this lots in evidence but ***I think a lot of it is how you make your sure system is as collaborative and as open as possible so you can listen to the real experience of staff and the challenge is how you manage that....but it is around culture in the service and I think that really matters. Because you're asking staff to put themselves in harm's way and so how you listen to them and value them I think really does matter.*** *"* **[35/84/2]**

[1] On 18th January 2023 the Group of Welsh Health Bodies (GWHB) was granted Core Participant (CP) Status for Module 3 of the Covid-19 Public Inquiry: Aneurin Bevan University Health Board (ABUHB); Betsi Cadwaladr University Health Board (BCUHB); Cwm Taf Morgannwg University Health Board (CTMUHB); Hywel Dda University Local Health Board (HDULHB); Swansea Bay University Health Board (SBUHB); and Velindre University NHS Trust (excluding NHS Wales Shared Services Partnership) VUNHST.

3. A similar question about lessons learned from the Inquiry was asked of the First Minister Baroness Eluned Morgan. After noting that in Wales the "*NHS estate is poor, so additional capital investment would be helpful*" and that there is currently a concerted effort to try "*to get more separation between planned care and emergency care*" she said:

   "So I think the other thing is just to -- ***I think the NHS did remarkable work, and I think the staff on the front line did remarkable work and there's a lesson there as well to empower the frontline workers I think, give them responsibility. We gave them responsibility and we empowered them with a lot of money. It's very difficult to do that in times of peace but what they did was just incredible under the circumstances, and they acted really, really quickly. And, you know, if we could bring some of that magic back now it would be wonderful."*** **[35/182/1]**

4. The GWHB endorse these observations. They chime exactly with the sentiments and evidence expressed in writing and orally to the Inquiry from the Group, and were encapsulated in the oral and written evidence of Professor Kloer from the spotlight hospital in Wales chosen by the Inquiry, Glangwili. He too was asked a similar question at the close of his evidence by CTI:

   Q. *You have very helpfully set out a number of recommendations in your statement. Are there perhaps one or two that you wish to particularly draw to her Ladyship's attention?*

   A. *So I think considering physical estate in future* ***pandemic planning*** *is important, given our experience. I think some of the risk -- the sort of statistical modelling around outbreaks for both -- the pandemic and non-pandemic issues I think would be important. If I might be allowed two very quick other ones.* ***Learning*** *-- in our report we've been very open about our report on staff well-being, the positives and the negatives, and I think many of the hospitals will have undertaken similar work in learning what best supports staff well-being in these situations. And lastly, I would say really much earlier awareness of the* ***impact on vulnerable groups****, so learning what support we should be applying very early on in a pandemic situation to any vulnerable group I think would be important.* **[30/173/2]**

5. The overarching submission that the GWHB make at the close of the oral evidence is that it was clear in Wales the GWHBs were working within considerable constraints, in particular infrastructure and resources. Despite this, the GWHB in fact performed remarkably well in those difficult circumstances and have, through initiatives such as the transparent reporting of staff concerns, (e.g. through the staff survey) sought to learn the lessons of what worked and what did not work well in the pandemic so as better to improve their services for the future.

Detailed submission

6. The GWHB has provided a number of written statements in response to Rule 9 requests in respect of[2]: Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cardiff and Vale UHB* , Cwm Taf Morgannwg UHB, Hywel Dda UHB, Powys Teaching Board*, Swansea Bay UHB, and Velindre University NHS Trust.

7. The GWHB repeat their opening submission that the Inquiry has now before it a wealth of written evidence from the UHBs and from Velindre University NHS Trust in Wales, which gives a substantial amount of data as to the specific impacts of the pandemic, as well as insights into lessons which might be learned for the future. In addition to the oral evidence it has heard, that evidence can be found in the statements of:

   (i) Glyn Jones (former interim CEO Aneurin Bevan) **[INQ000303293]**

   (ii) Nicola Prygodzicz (Aneurin Bevan) **[INQ000421871]**

   (iii) Joanne Whitehead (former CEO Betsi Cadwaladr) **[INQ000292766]**

   (iv) Gill Harris (former Interim CEO Betsi Cadwaladr) [INQ000309004]

   (v) Pamela Wenger (Director of Corporate Governance, Betsi Cadwaladr) **[INQ000421872]**

   (vi) Professor Meriel Jenney (Executive Medical Director) and Professor Stuart Walker (Chief Medical Officer) (Cardiff and Vale) **[INQ000480136]**[3]

   (vii) Paul Mears (CEO Cwm Taf Morgannwg) **[INQ000474238]**

   (viii) Steven Ivor Moore (CEO Hywel Dda) **[INQ0003087889]**

   (ix) John Huw Thomas (Director of Finance, Hywel Dda) **[INQ000492257]**

   (x) Hayley Thomas (CEO Powys Teaching Board) **[INQ000421870]**

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[2] The asterisked bodies are not formally members of the GWHB CP Group but have provided R9 responses as noted above.

[3] Professor Jenney's statement contains a very helpful distillation of particular difficulties which were confronted at the largest hospital in Wales, one of the largest in the UK, for example, difficulties in dissemination and implementation of guidance §144-145; difficulties due to physical condition and layout of hospital §149; implementation of the NHS Wales Visiting Guidance §197-198 etc.

(xi) Tracy Myhill (CEO Swansea Bay) **[INQ000300701]**

(xii) Mark Hackett (CEO Swansea Bay) **[INQ000355777]**

(xiii) Dr Keith Reid (Executive Director of Public Health, Swansea Bay) **[INQ000492251]**

(xiv) Steve Ham (CEO, Velindre University NHS Trust) **[INQ000283961]** and **[INQ000421761]**

(xv) Professor Richard Adams (Consultant in Clinical Oncology Velindre) **[INQ000412897]**

(xvi) Professor Philip John Kloer, (Deputy Chief Executive of the Hywel Dda UHB) **[INQ000475209]**

Structure of Healthcare System in Wales

8. As summarised in our opening statement it is important to understand the structure of the Healthcare system in Wales, see for example the statement provided by Dr Andrew Goodall **[INQ000485721]** at §34. Substantial detail as to the functioning of the Health Boards and NHS Trusts in Wales is also given in the detailed first statement provided by Ms Judith Paget on behalf of the Welsh Government **[INQ000486014]** at §13-37. The Chair will recall that Ms Paget gave evidence to the Inquiry of both her experience as CEO of the NHS in Wales and in her former capacity of Chief Executive at Aneurin Bevan UHB (until October 2021).

General Themes

9. The general themes which emerged in both the initial written statements by the GWHB, and built on in oral evidence, included the clarification that the main source of the Guidance and Advice given to the Local Health Boards in Wales emanated from the Welsh Government with whom there was and continues to be a good and close working relationship. The view of, for example, Joanne Whitehead at Betsi Cadwaladr UHB was that the consultative and collaborative approach that was taken by the Welsh Government towards the Health Boards "*was effective and worked well*". **[INQ000292766]** This sentiment is echoed in other written statements to the Inquiry such as Tracey Myhill, who was CEO at Swansea Bay at the outset of the pandemic:

"I was confident that there were good lines of communication between the Health Boards and the Welsh Government. My impression as Chief Executive was that SBUHB was more than able to keep the Welsh Government informed of developments within our organisation and in the community that we served. We were kept appraised of developments in terms of the Welsh Government's response to the pandemic and the modelling undertaken." **[INQ000300701]**

10. To similar effect but also underlining that the UHBs retained a degree of freedom to manage their issues locally, see the statement of Mark Hackett, former CEO also of Swansea Bay UHB:

    "I would say that during the period when I was CEO the Welsh Government gave the Health Board a reasonable level of freedom to shape its own responses to the challenges that we were facing as regards these issues. I did not feel that we were being micro-managed." **[INQ000355777]**

11. That evidence has to be seen against the backdrop of the oral and written evidence given by Sir Frank Atherton (CMO for Wales) the general tenor of whose evidence was that the Welsh Government and local health boards worked well and cooperatively together in response to the very challenging circumstances of the pandemic.

12. Similarly, a feature of Dr Andrew Goodall's evidence was that it was clear that Public Health Wales was in constant communication with the health boards and was not disabled from functioning from lack of data. The group would also note from the oral evidence of Dr Goodall that he thought the response of NHS staff in Wales was "*extraordinary*". His view was that it was highly professional, committed and that things worked best when the Welsh Government worked collaboratively with local health boards and frontline staff. In the middle of all the various structures, it was, he said, "*important to recognise that the collaborative working that came out of the pandemic was a really good thing.*" The Group of Welsh Health Bodies agree.

Spotlight Hospital

13. The Inquiry received evidence from Professor Philip Kloer, who was Medical Director and Deputy Chief Executive of Hywel Dda University Health Board at Glangwili General Hospital during the pandemic. In addition to his witness statement **[INQ000475209]**, Professor Kloer gave evidence to the Inquiry orally. The overall impression which his evidence created was that the Glangwili Hospital had faced considerable challenges

due to its infrastructure and capacity, but rose successfully to the complex challenges caused by the Covid-19 pandemic in a way that was caring, compassionate and conscientious.

14. To the great credit of Professor Kloer and his hospital, it was clear that the Glangwili Hospital had engaged with staff in an open and transparent way through staff surveys and other internal reviews and recognised that; "*[our staff] have responded to the needs of our population in dealing with the pandemic and have gone above and beyond the call of duty at every opportunity. They have at times compromised their own health and wellbeing and home and family life to support our patients and colleagues and have worked to ensure that appropriate 24/7 care has been available to meet patient needs across our three counties.*" **[INQ000466548/2]**

15. It was clear from Professor Kloer's evidence that this proactive approach meant that Glangwili Hospital management were able to, and did, identify and understand specific concerns raised by staff and patients e.g. with respect to PPE, and two reported matters relating to DNR orders (one relating to Glangwili, the other to Withybush General Hospital). Professor Kloer gave clear evidence of how the Health Board was responsive to such concerns and while he did not seek to diminish the '*lived experience*' of those who identified such issues, it was clear that there had been an entirely proper, balanced and considered response to the concerns that were raised, whether it be vaccine roll-out, lateral flow testing, or '*purposeful*' implementation of centralised IPC guidance to an ageing infrastructure at Glangwili.

Challenges to the hospital estate

16. As to the hospital infrastructure Professor Kloer identified what is a fairly common theme in the evidence from Wales, that the buildings infrastructure gave rise to practical problems implementing IPC Guidance. The challenges to the hospital estate in Wales raised a number of potential problems identified in the evidence e.g.:

    - Hospitals featured narrow, limited side rooms;

    - Staff rooms were often too small;

    - There was "no on-ward changing, no formal ventilation apart from a very small number of isolation rooms. Making it difficult to comply with guidance." **[INQ000480136]**

- Health Boards had a difficult choice between reducing patient numbers and appropriate space (using Perspex) or using outside capacity e.g. additional beds in the private sector and step down beds through field hospital arrangements. **[INQ000396261/8]**

17. It was equally clear that there is no "quick fix" to this problem given the strain on national resources. That said, in her oral evidence Ms Judith Paget referred to the allocation of some £34 million that was made available in 2021, 2022 and subsequent years, to address issues related to ventilation. She added that the most recent hospitals built have an increased number of single rooms which is a very positive feature, and that this has an important impact on hospital-acquired infections. **[31/142/2-31/142/23]**

Command structures

18. As to command structures, each of the Health Boards adopted a Gold, Silver and Bronze command structure. The Gold Command was the internal strategic decision-making body with executive leadership. Silver Command was usually an organisation-wide operational structure led by a Chief Operating Officer or equivalent. Silver Command would deal with tactical and day to day operational issues and would make immediate responses to particular issues. Should decisions require escalation then these were brought to the Gold Command. Below Silver Command was the Bronze Command which was usually a more locally based decision making body which could escalate to Silver where necessary. An example of that operational structure is summarised in the evidence of Paul Mears (CEO of Cwm Taf Morgannwg UHB). **[INQ000308947]**

Staffing capacity

19. As outlined in Professor Kloer's detailed statement, staffing capacity, already a problem before the pandemic, was compounded by Covid-related sickness, but a recruitment drive commenced in March 2020 resulted in the creation of around 1,100 new staff. He explains how bed capacity was increased, and in fact GGH never reached the position where an ICU bed, if required, could not be found for a patient. However, as in other places across the UK, it was quickly realised ventilating patients, particularly older patients with co-morbidity, was not the best treatment when respiratory support was required, and less invasive modes such as CPAP were more efficacious.

20. He highlights an issue (echoed in other statements from the GWHBs) that the frequent changing of guidance, particularly during the pandemic onset, caused obvious practical problems but also staff confusion and anxiety. In similar vein to concerns identified by Velindre NHS Trust, he points to the fact that Public Health England guidance was usually announced on a Thursday but Public Health Wales on the following afternoon (Friday). This led to initial difficulties in implementation.

PPE

21. In similar vein to the reports of other UHBs, he reports that sourcing of PPE was not the problem that might have been anticipated. The Health Board procurement teams were able to procure equipment appropriately and although there was considerable anxiety in relation to PPE stock and supplies of face masks at one point reached critical levels at GGH, supply was not an issue and neither were there significant delays in obtaining equipment once ordered.

22. That is not to say there were not some practical difficulties (see in particular his evidence **[INQ000475209]** at §124 etc.) but overall, 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 the staff worked reasonably well with the equipment supplied.

23. The GWHB would note that this evidence is broadly reflective of the expert evidence commissioned by the Inquiry in relation to PPE/IPC across the nations (see the expert reports of Dr Gee Yen Shin, Professor Dinah Gould, Dr Ben Warne and that of Professor Beggs).

Visiting restrictions

24. As to visiting restrictions and the difficult balance that had to be struck, the overall view was that the hospital did its best and probably struck the right balance through specific arrangements supported with all necessary PPE. Professor Kloer goes on to give a detailed account of other matters of specific interest to the Inquiry including the impact on patient care, the impact on hospital staff, use of DNACPR forms and Equality Impact Assessments.

Recommendations

25. In terms of lessons learned and recommendations, the issues which Professor Kloer identified in his witness statement and oral evidence are eminently sensible and based on his direct experience of working as a respiratory physician but also as Deputy Chief Executive during the pandemic. It was clear that he had worked tirelessly throughout this period and conscientiously sought to meet, and to a large extent had successfully responded to, the challenges that arose.

26. The GWHB note that many of the recommendations he identifies chime with matters that other Health Boards have also identified, and the GWHB would endorse the following suggestions:

    (i) Any future recommendations would need to look at the existing infrastructure of hospitals in parallel with future pandemic planning.

    (ii) All modern hospitals should be designed with pandemics and/or serious infection outbreaks in mind with existing buildings being upgraded.

    (iii) Pandemic planning needs to develop resilience in staffing, medical equipment and supplies.

    (iv) 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.

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

    (vi) The creation of a reserve workforce - both skilled and volunteer - would assist with staffing resilience.

    (vii) The importance of national coordination of the senior clinical voice across Wales, to ensure rapid sharing of experience and learning should be recognised.

    (viii) Drawing on the experience of Covid, have pre-prepared Guidance developed from the learned experience of Covid, that could be rapidly adapted, disseminated and implemented.

(ix) Harness the learning from the rapid development of vaccines to be applied to future pandemics.

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

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

Some key insights

27. Further, and in what is not supposed to be an exhaustive survey of the Group's responses, GWHB draw the Inquiry's attention in addition to a number of similar insights from its bodies and those of Cardiff and Vale UHB.

Communication and messaging

28. Paul Mears (Cwm Taf Morgannwg UHB) **[INQ000308947]** explains:

> "*I believe that, whilst mass communication from Welsh Government to the public regarding restrictions and the implications of the pandemic were necessary, there could have been a more targeted communications approach with particularly vulnerable communities working in partnership with Local Authorities to try and target areas where compliance with restrictions was low. Greater collaboration on this area could have helped our local efforts to encourage adherence to the national rules and restrictions.*"

29. A similar concern was identified by Mr Steve Ham CEO of Velindre University NHS Trust who noted at **[INQ000283961]** §125 that "*the consistency and speed of national guidance provided tended to be issued late on a Friday, which was difficult to communicate to staff ready for Monday".* He suggested a recommendation that guidance should be reviewed and released at the beginning of a working week to allow for the guidance to be clearly understood and disseminated efficiently.

Hospital discharges

30. Tracy Myhill (former CEO Swansea Bay UHB) identified at **[INQ000300701]** §76 of her statement that:

"The general presumption, shared by many across NHS Wales, was that measures put in place to protect residents in care homes, (e.g. PPE, full barrier care of all residents if either residents or staff presented as symptomatic or tested positive, early testing of symptomatic care staff, along with any new admission to a care home being isolated for 14 days), would control infection and enable it to be safely managed in a care home setting. With hindsight this is questionable. This has been and will remain an area for lessons learned, not only during the course of the pandemic with the issuing of revised guidance, but for future management of infectious outbreaks to find alternative means to free up acute hospital capacity whilst preventing the transfer of infection into care homes".

Workforce

31. Professors Jenney and Walker at **[INQ000480136]** §316 identify valuable *"Institutional learning from the Covid-19 pandemic,"* including that the workforce needs to be the *"core currency"* when considering a pandemic. They suggest that there can be a natural bias to focus on facilities and beds which the Nightingale programme reflected, however, in their view at the University Hospital of Wales, it was consistently workforce capacity that dictated success.

Striking a balance between the need for pandemic response and need for the continuation of other urgent health services

32. Professors Jenney and Walker also identify (as do many of the independent experts and other GWHB witnesses who have reported to the Inquiry) that striking the right balance between, on the one hand, the need for an urgent healthcare response to the pandemic illness or illnesses, and on the other, the need to preserve and continue other urgent healthcare interventions (e.g. cancer, cardiology, sight-saving appointments etc.) for patients is a *critical lesson* which must be learned. During the Covid-19 pandemic, some patients feared contracting Covid-19 in hospital and a number that should have sought care did not (on this issue the Inquiry is referred to its own expert evidence commissioned into Colorectal Cancer and Cardiology specialisms).

33. Views have also been expressed that routine services could in some areas have re-started more quickly, a point emphasised in the evidence of Joanne Whitehead former CEO at Betsi Cadwaladr UHB **[INQ000292766]** §21:-

"there was a growing dialogue between the Health Boards and Welsh Government around the need to resume … services in the interests of patient welfare. It seems to me that in responding to any future pandemic it will be necessary at an early stage to explicitly consider the balancing exercise between the protective policies necessary to combat the emergency and the potential for harm caused by delay in the resumption of healthcare services."

34. The overarching message is that it is important, even in a pandemic, to continue to focus on other urgent services and there should be robust plans in place to ensure that core services do not cease.

35. The Group of Welsh Health Bodies note that there was some criticism directed at PHW during Dr Goodall's evidence regarding the delay between the decision to stop elective surgery on 13 March 2020 pursuant to an instruction from the Minister Vaughan Gething and the subsequent delay in PHW ensuring a restart to elective surgery. In this regard, CTI made reference to the expert report of Metcalfe and Scott, who say the delivery/restoration of healthcare in Wales in particular was delayed. The GWHBs note from Dr Goodall that it is suggested that in the future 'elective hubs' may be a way of ensuring an earlier restart to such services. **[31/25/12].**

Assessment of vulnerable groups

36. Gill Harris (former Interim CEO Betsi Cadwaladr UHB) in her statement identifies that amongst the other key lessons learned was the need for prior assessment of impact on vulnerable groups **[INQ000309004]**. North Wales has a high proportion of socially deprived and vulnerable communities, the consequence of which is that when lockdowns were imposed there was an unanticipated impact on the delivery of healthcare services to those communities. There is a lesson to learn from the experience of mixing elective and emergency services. Elective services were disproportionately affected and for the future there is an opportunity to handle these differently.

Cancer specific recommendations

37. Mr Steve Ham CEO of Velindre University NHS Trust, identifies at **[INQ000283961]** §123 onwards a number of cancer-specific lessons that should be learned, and addresses issues in respect of IPC and infrastructure which mirror concerns expressed in the expert evidence already provided to the Inquiry. These recommendations may

usefully be read alongside the expert evidence commissioned by the Inquiry on IPC (Shin/Gould/Warne) and Colorectal Cancer (Bhangu and Nepogodiev). Mr Ham notes in particular that there should be:

(i) protection of the cancer pathway from diagnosis through to all treatment options should be maintained by segregation as far as possible of 'clean' treatment areas and will be particularly important in the event of any future pandemics.

(ii) UK-wide urgent cancer treatment guidelines should continue to reflect any treatment changes to reduce patient risk from a pandemic. This will ensure consistency and also prevent duplication of effort across the UK

(iii) That with respect to IPC, reviews of pandemic stock be regularly undertaken to ensure that stock retains the relevant documentation and labelling for safe use.

Summary

38. The Inquiry will already be aware from the two statements from Ms Judith Paget in her capacity as Chief Executive of NHS Wales that a considerable amount of work has already been carried out in Wales in terms of seeking to learn lessons from the Covid-19 pandemic. In particular, Annex A to the second statement of Ms Judith Paget **[INQ000485240]** produces a chronological table of reviews, lessons learned exercises or similar produced or commissioned by the Welsh Government relating to the issues in the Provisional Outline of Scope for Module 3 since 1 March 2020. This is all part of a firm commitment on behalf of all health bodies in Wales to seek to continue to improve the services they provide for the benefit of patients and in the wider public interest. Ms Paget was asked at the end of her evidence whether the patchwork of reviews which had been carried out had been sufficient:

Q: Are you confident that the various patchwork of reviews performed has identified, together, all of the lessons to be learnt from the pandemic response in Wales?

A. So I am confident that it has. I am confident that organisations have learnt individually what we are now going to be doing. And I know you want me to ask me about the NHS Wales Executive, but, just in response to this question, we are now going to be reviewing all of the plans that NHS organisations have updated, following their own learning lessons and reflections. We will review those both individually with organisations and collectively through the NHS Executive, and if there are any further learning or lessons that we need to address then we will do so.

Closing remarks

39. Much learning has already taken place. There is no question that to build resilience to a future pandemic, the hospital infrastructure and estate in Wales needs capital funding and upgrading including improving ventilation systems, elective hubs etc. Of course one must be realistic as to the resources and the capital funding available to the Government in Wales for hospital improvements but the Group of Welsh Health Bodies live in hope. As the Chair observed to Professor Kloer at the end of his evidence "*even institutions that start with Nissen huts can become like Heathrow, so you never know. You may get your hospital into Terminal 5 state*".

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19 December 2024

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