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| Witness Name: | J C White |
| Statement No: | 1 |
| Exhibits: | M2B.CNO.JW.01/001 – 146 |
| Date: | 05/12/2023 |

**UK COVID-19 PUBLIC INQUIRY**

**WITNESS STATEMENT OF PROFESSOR JEAN CHRISTINE WHITE CBE MStJ**

I, Professor Jean Christine White CBE MStJ, state as follows: -

1. I make this statement in response to a request pursuant to Rule 9 of the Inquiry Rules 2006 with reference M2B/CNO/JW/01 and dated 5 May 2023.

**Introduction**

2. I extend my deepest sympathies to those who have lost loved ones or suffered hardship or long-term difficulties as a consequence of the pandemic.

**My background and qualifications**

3. I was appointed to the role of Chief Nursing Officer for Wales ("CNO(W)") on 29 October 2010 and held this position until I retired from the Civil Service on 6 April 2021. I was a permanent, full time civil servant within the Welsh Government. This position was a director level appointment in the Senior Civil Service. I also held the title of Nurse Director of NHS Wales, though I was not an employee of the NHS. This title reflected the fact that Welsh Ministers and the civil servants who supported them had direct oversight of NHS Wales. Similarly, other civil servant directors in the Welsh Government held NHS facing role titles, e.g., the Director General of the Health and Social Services Group ("the Director General, HSS"), Dr Andrew Goodall CBE was

also the Chief Executive Officer of NHS Wales, and the Chief Medical Officer for Wales ("CMO(W)"), Sir Frank Atherton was also the Medical Director of NHS Wales.

4. I am professionally qualified as a registered nurse (adult) and as a registered nurse teacher with the Nursing and Midwifery Council ("NMC"). I completed my state registered nurse training in Swansea in 1982, then worked for six years as a clinical nurse in operating theatre departments in South Wales and London. During this time, I completed a one-year full time post registration course in operating department nursing, and a Higher Education Diploma in Nursing.

5. In autumn 1988, I moved to a teaching position with the West Glamorgan School of Nursing, Swansea, to run the operating theatre and anaesthetic nursing courses. I completed a full time Certificate of Education (Further Education) at Cardiff University in 1989/90 and became a registered nurse teacher. I returned to Swansea and participated in the move to university-based education in 1992, when I became an employee of Swansea University. I worked as a nurse lecturer and senior lecturer (promoted 1994). I mainly taught on the diploma, degree and master's in adult nursing programmes and managed the registry function for the Department of Healthcare Studies. I furthered my education by completing a Bachelor's Degree in Nursing (BN) (1992) and then a Master's Degree in Healthcare Management (MSc) (1998); both completed alongside my day job.

6. In September 2000, I moved to the Welsh National Board for Nursing, Midwifery and Health Visiting. This body was part of the UK regulatory system for nurses, midwives and health visitors and was responsible for ensuring the standards of nurse and midwife education and training in Welsh higher education institutions. I was initially a professional nurse advisor but became the Director of Quality and Standards.

7. While in this post, I was invited to become a member of the European Commission team working with the governments of Slovenia, Estonia, and the Czech Republic to determine in-country nurse regulation and education readiness, to support their succession to the European Union (2002-2003).

8. The Welsh National Board for Nursing, Midwifery and Health Visiting closed in March 2002 and was replaced by the current UK regulator, the Nursing and Midwifery Council. I moved then to the new non-departmental public body, Health Professions Wales, which quality assured nursing and midwifery education in Wales on behalf of the NMC

and undertook workforce development programmes for healthcare professionals in NHS Wales. While there, I began a part time PhD study in the School of Social Science, Cardiff University in October 2002.

9. In April 2006, when Health Professions Wales closed, I moved to the Welsh Government as a nurse adviser within the office of the Chief Nursing Officer. I completed my PhD in December 2006. My responsibilities as nurse adviser were to provide governmental advice on education and training of nurses, nursing workforce, safeguarding vulnerable adults, and nursing care of older people.

10. In 2009, I was seconded to the World Health Organisation ("WHO") for three months (Geneva and Copenhagen offices) to undertake leadership development with the nurse leads for the WHO. I have been recognised as an expert nurse adviser to the WHO European Office since 2013 and I have undertaken various activities with them, for example I helped draft the Strategic Directions for Nursing and Midwifery in WHO European Region (2015-2020) and I participated in the launch of the strategy in Lithuania in September 2015. I was also asked to represent the WHO European Region on the WHO global group developing guidance on the preparation and role of community health workers in 2018/19.

11. During my time as CNO(W), I became an honorary visiting professor of nursing at Cardiff University in January 2011, a position I held until my retirement in 2021. I was also appointed as a visiting professor of nursing at the University of South Wales in 2016, and I continue to hold this role in my retirement. Both roles involved occasional lecturing of undergraduate nursing students and advice on policy development within the Schools of Nursing and Midwifery.

**The role of the Chief Nursing Officer for Wales prior to the pandemic**

12. In my role as CNO(W) I was the head of the nursing and midwifery professions in Wales (circa 36,000 practitioners) and, as such, I set the professional agenda and future direction for these professions. I was the senior adviser to the Welsh Government on professional matters relating to the nursing and midwifery professions.

13. I was responsible for the professional performance and development of the executive nurse directors in the seven local health boards, three NHS trusts, and the Welsh Health Specialist Services Committee in NHS Wales ("the Nurse Directors"). I

performed a significant professional role in the Welsh Government's oversight of NHS Wales's delivery and performance, and I participated in performance review meetings with NHS Wales organisations led by the Director General, HSS.

14. Prior to the Covid-19 pandemic, I chaired monthly meetings with the Nurse Directors. I also chaired six-monthly performance meetings with the clinical leads and senior executives responsible for maternity services in NHS Wales organisations.

15. When specific organisations were deemed to be failing to meet the expected level of performance, scrutiny was escalated (under direction of the Minister for Health and Social Services) and more frequent performance meetings were held. For example, maternity services at Cwm Taf Morgannwg University Health Board were put into special measures in April 2019 due to significant failures in the quality and safety of their service, and an independent maternity services group was established to oversee improvements, which was managed by civil servants in my Nursing Directorate and in the Quality and Safety Directorate (part of the CMO(W)'s Division). The Health Board came out of Special Measures in November 2022. I produce here, as exhibits **M2B.CNO.JW.01/001–INQ000300067**, **M2B.CNO.JW.01/002–INQ000300068**, and **M2B.CNO.JW.01/003–INQ000300069**, the Cwm Taf Morgannwg UHB maternity services report dated April 2019, the progress report on Cwm Taf Morgannwg UHB maternity services dated September 2022, and a written statement by Eluned Morgan MS, Minister for Health and Social Services on 7 November 2022.

16. I headed a small directorate comprising five nursing officers, who each offered professional advice to policy making departments and led policy development in one of more of the few specific areas that fell to the jurisdiction of the Office of the Chief Nursing Officer, namely maternity services, breastfeeding, health visiting services, school nursing services, patient experience in NHS Wales, the Nurse Staffing Levels (Wales) Act 2016, health of people with learning disability, and NHS Wales safeguarding procedures, including oversight of the NHS Wales Prevent coordinators. The nursing officers, and their primary areas of responsibility, were as follows: --

    16.1. Karen Jewell, midwifery adviser and policy head for maternity services, development of health visiting services, and school nursing services. Karen worked with the policy leads for neonatal services, quality & safety, child health, and childhood vaccination, which all sat in the CMO(W)'s directorate. She also worked with the Education Department due to the interface between teachers

and school nurses, and externally with Public Health Wales officials on areas like breastfeeding, childhood vaccinations, and early years programmes.

16.2. Paul Labourne, nurse adviser for out of hospital nursing care. Paul worked mainly with the Primary Care Directorate headed by Frances Duffy, Director of Primary Care and Health Science, and the policy leads for care homes in the Social Services Directorate headed by Albert Heaney, then Deputy Director General of Social Services & Integration ("Deputy Director General, SS&I").

16.3. Hazel Powell, nurse adviser for mental health nursing, learning disability nursing and policy lead for improving the health of people with learning disabilities. Hazel had oversight of a three-person team addressing the recommendations from the cross-Welsh Government review of policies that address the needs of people with a learning disability, called Improving Lives. I produce here, as exhibit **M2B.CNO.JW.01/004–INQ000300070**, a report on the improving lives programme, dated June 2018. Hazel worked mainly with the Mental Health Directorate (headed by Jo-Anne Daniels, Director of Health, Vulnerable Groups and NHS Governance) and the Social Services Directorate (headed by Albert Heaney, Deputy Director General, Social Services & Integration) in relation to learning disability, and the Education Department and several other directorates in relation to school age children and special education needs.

16.4. Gillian Knight, nurse adviser for education and training of nursing staff, NHS Wales safeguarding procedures (including oversight of NHS Wales Prevent coordinators), and implementation and expansion (to cover paediatric wards) of the Nurse Staffing Levels Wales (2016) Act. Gillian worked with the Workforce & Organisational Development Directorate (headed by Helen Arthur, Director of Workforce and Corporate Business) and the quality and safety team in the CMO(W)'s directorate. She also worked with Health Education and Improvement Wales, and the Council of Deans Wales.

16.5. Gareth Howells, nurse adviser for patient experience in NHS Wales, which included hospital catering and patient nutrition & hydration, continence management, prevention of falls in NHS Wales settings; preventing healthcare acquired infections, prevention of tissue damage and the management of serious incidents reported in NHS Wales settings. Gareth worked with the

quality and safety team in the CMO(W)'s directorate, and the infection prevention team at Public Health Wales.

17. These five nursing officers were supported in their work by a small team of junior civil servants. I produce here as exhibit **M2B.CNO.JW.01/005–INQ000300071**, a structure chart showing how the Nursing Directorate was organised, and I also produce here a structure chart showing the Nursing Directorate's place in the wider Health and Social Services Group ("HSSG"), as exhibit **M2B.CNO.JW.01/006–INQ000177492**.

18. I was line managed by, and reported directly to Dr Andrew Goodall CBE, who at that time was the Director General of the Department of Health and Social Services. I directly advised the Minister for Health and Social Services and the Deputy Minister for Social Services on matters related to my portfolio of responsibility described above.

19. I did not have a specific role in respect of public health emergencies but was part of the collective response staged by the Welsh Government, with the support of Public Health Wales. I was not involved in pre-pandemic planning meetings, but I was a member of the CMO(W) and Public Health Wales led Health Protection Advisory Group, established in February 2018, that provided multidisciplinary multiagency advice on all potential public health challenges. The Health Protection Advisory Group continued to work throughout the pandemic, although its terms of reference were amended on 24 August 2020, with increased membership and increased frequency of meeting. I produce here, as exhibits **M2B.CNO.JW.01/007–INQ000180630** and **M2B.CNO.JW.01/008-INQ000220657**, the terms of reference dated February 2018 and September 2020 respectively.

20. There was a statutory Welsh Nursing and Midwifery Committee that provided a forum to discuss professional nursing and midwifery issues. This was one of several statutory health professional committees advising the Welsh Government. The chairs of these committees attended the National Joint Advisory Committee, normally chaired by the CMO(W). The chairs also met with the Minister for Health and Social Service annually. The Welsh Nursing and Midwifery Committee had a membership of 19 mostly frontline staff and educators, and it met on a quarterly basis. I produce here as exhibit **M2B.CNO.JW.01/009–INQ000300072**, the committee's terms of reference. The Welsh Nursing and Midwifery Committee provided advice to me in my role as CNO(W) and through me to Welsh Government officials and Ministers. In the initial period of the pandemic in 2020, the meetings were paused to allow the representatives to focus all

their time on operational matters. This meant that the first meeting held in the calendar year of 2020 was on 7 September, and I produce here as exhibit **M2B.CNO.JW.01/010–INQ000300073** the minutes of that meeting. This meeting provided an opportunity to reflect on what had happened during the pandemic to date and consider what lessons could be drawn from members' experiences. Regular meetings resumed at this point.

**The initial phase of the pandemic response in Wales**

21. I was made aware of the increasing threat to public health from Covid-19 through the weekly team meetings that the Director General, HSS held with the HSSG Executive Directors ("EDT Meeting(s)"). The information shared with Executive Directors during these meetings was provided mainly by the CMO(W) and the communications department. For example, at the EDT Meeting on 29 January 2020, the Communications Lead, Rebecca Tune, gave an overview of what was being reported internationally, and I produce here, as exhibit **M2B.CNO.JW.01/011–INQ000300083**, the minutes of that meeting. On 5 February 2020 an update was given by the CMO(W); the minute of that meeting (produced here as exhibit **M2B.CNO.JW.01/012–INQ000300084**) reads, *"…the UK/Global position - weekly meetings of COBRA, weekly meetings of the UK CMOs. Wales is preparing for the first cases. He was pleased with PHW's preparations."* Use of the Pan Wales Response Plan (which I produce here as exhibit **M2B.CNO.JW.01/013–INQ000107119**) as a starting point for pandemic response planning, was also discussed at this meeting.

22. From this point on, updates on Covid-19 were given at every EDT Meeting, amid escalating concern about the global spread of the virus. The Director General, HSS shared information on preparations for the potential spread to Wales, including the statements the Minister for Health and Social Services would make to keep the Senedd and the public informed.

23. The escalating public health threat was taken very seriously by all directors, and plans were developed at pace to reprioritise the work of the Welsh Government to address the growing health emergency. I felt I was told at the appropriate time and was kept up to date throughout the pandemic. In the following paragraphs, I will summarise the discussions held at EDT where I was able to contribute my professional view. Aside from discussions at EDT, I had professional conversations within my team and with the Nurse Directors, and I spoke with civil servants with whom I and my team normally

worked. I did not, however, lead on developing ministerial briefings in this period in relation to the emerging health emergency.

24. I produce here the minutes of the EDT meeting held on 26 February 2020 as exhibit **M2B.CNO.JW.01/014–INQ000300085**, which document the decision to implement specific supporting arrangements, namely, the establishment of the NHS Planning and Response Cell, led by Samia Saeed-Edmonds, and the standing up of the emergency helpdesk for health and social care staff and the public who use these services. The CMO(W) reported on his meetings with the Chief Executives for local health boards and NHS trusts in Wales, to review plans to respond to the health emergency, and his meeting with the Permanent Secretary of the Welsh Government, then Dame Shan Morgan DCMG.

25. The First Minister ("FM") asked civil servants in Wales to identify what work could be paused, or stopped, to free up resources that could be redeployed to the pandemic response. A list was agreed at the EDT meeting on 19 March 2020, and subsequently submitted to the FM for agreement. I produce here, as exhibit **M2B.CNO.JW.01/015–INQ000300086** the minutes of the EDT meeting on 19 March 2020, and the list of activities which the HSSG proposed to pause as exhibit **M2B.CNO.JW.01/016–INQ000299051.**

26. Also, during the EDT meeting on 19 March 2020, there was a discussion about the potential use of national lockdowns, as the efforts at this early stage, before Covid-19 had spread to Wales, were aimed at 'flattening the curve' of the peak of the disease outbreak. There was widespread concern expressed by chief executives in the health service at this point that the number of cases could overwhelm NHS services in Wales unless action was taken to lessen the potential of a rapid increase in numbers of ill patients accessing all parts of the NHS, which included primary care services. We agreed that actions were therefore needed to reduce the routine provision of care and free up resources across NHS Wales to deal with the anticipated influx of patients with the infection. In this meeting, we also discussed the need to source more ventilators, considered options for critical care capacity, the Minister for Health and Social Services' announcement about the actions the NHS was to take, an assessment of testing capacity (which stood at 800 per day at this point), shielding of vulnerable people identified from GP lists, and actions related to PPE in care homes. The agreed actions were then acted upon by the responsible director. Due to concerns expressed by the NHS CEOs, as reported in the meeting on 19 March 2020, the Health Boards

were asked to prepare status reports on the actions they were taking to create capacity within the health system. This was reported on in the next EDT meeting on 25 March 2020 (the minutes of which I produce here, as exhibit **M2B.CNO.JW.01/017–INQ000300087**. It is my recollection that ensuring appropriate levels of PPE to be delivered to local authorities and care homes remained challenging for some weeks. Albert Heaney kept in contact with the social services leads to help facilitate where possible, however supply of PPE was not just an issue for social services.

27. One of the early challenges the Welsh Government faced was in securing sufficient quantities of PPE for use in the health and social care services. We did not produce equipment in-country and therefore had to rely on supplies from other countries, and these supply chains became unreliable. Alan Brace, Director of Finance in the Department of Health and Social Services, attended the PPE Cell to address all issues related to the supply of PPE in Wales, headed by Lee Waters MS. In the EDT meeting on 8 April 2020, Alan reported on the difficulties being experienced, e.g., the presence of counterfeit equipment that didn't offer protection to the wearer. It was the consensus view that Wales should work with the UK Government to utilise their sourcing resources, ensuring Wales was then allocated its share of the equipment secured in this way, rather than try to go alone. The longer the pandemic went on, and with increasing demand, there was a real possibility that Wales could run out of equipment. After the EDT meeting on 8 April 2020, Dr Andrew Goodall spoke to Simon Stevens, CEO NHS England, to ensure good working arrangements in this area. Working arrangements did improve over time, so much so that on occasion mutual aid between the four UK countries enabled some sharing of PPE when difficulties were identified. Wales both received from, and provided equipment to, other nations in the UK during the pandemic. I produce here, as exhibit **M2B.CNO.JW.01/018–INQ000300088,** the notes of the EDT meeting on 8 April 2020.

28. In the EDT meeting on 25 March 2020, in addition to moving the Welsh Government to a virtual way of working, we discussed the development of field hospitals with support from the Ministry of Defence; we received an update on plans from the seven local health boards in Wales to free up capacity, e.g. stopping some planned care, increasing availability of hospital beds, and relocating staff; redirecting funds to pay for the Covid-19 response work; the intention for CMO(W) and Public Health Wales to send letters to vulnerable people advising them to shield and maintain 2 metres social distancing; and an ability for GPs and other health professionals to do on-line consultations. I updated the executive directors on the restriction of hospital visiting

and the notice to the NHS that I planned to issue later that week (see paragraphs 57 to 62 of this statement), and I also reported on developing a list of recent (1-3 years) retirees who would be contacted with a request to return to work. The minutes of this meeting are exhibited at paragraph 26 of this statement, as exhibit **M2B.CNO.JW.01/017–INQ000300087**.

29. Through my discussions with the Nurse Directors during this initial phase of the pandemic, it became apparent that there was a need for national guidance on the restriction of hospital visiting to ensure a consistent approach across Wales. I produce here minutes of my meeting with the Nurse Directors on 18 March 2020, as exhibit **M2B.CNO.JW.01/019–INQ000299025.** I checked with the other UK CNOs to understand what their approach was and developed guidance for NHS Wales that aligned with other parts of the UK. I did not do this lightly as I was acutely aware that I would be restricting access of family and friends to their loved ones who were in-patients. However, reducing the risk of spreading the infection to other patients, staff, and members of the visiting public, a situation that carried the real potential to cause significant harm, had to take precedence. I issued a letter to the Nurse Directors on 25 March 2020, asking that they restrict visiting to inpatients not suffering from Covid 19 infection with three exceptions: permitting one parent or guardian to be with a paediatric (child) or neonatal (new-born baby) in-patient; women in labour to have one birthing partner from their household; and, with the advance agreement of the ward sister/ward manager, patients receiving end of life care could have one visitor for an agreed amount of time. Visiting to patients infected with Covid 19 was only to be undertaken in exceptional circumstances. This letter and subsequent letters and guidance made it clear that enabling people to say goodbye to loved ones at the end of their lives was to be facilitated wherever possible, and appropriate personal protective equipment ("PPE") should be provided for visitors to ensure their safety. I advised that pregnant women and people who had underlying health conditions that put them at greater risk from the Covid-19 virus should be encouraged not to visit. I produce here as exhibit **M2B.CNO.JW.01/020–INQ000299068**, the letter that I sent to Nurse Directors on 25 March 2020 providing guidance on hospital visiting. I provide a fuller chronology of the changes that I made to the national guidance on hospital visiting at paragraphs 57 to 62 of this statement.

30. The initial plans prior to the first national lockdown on 23 March 2020 involved a series of steps, with the aim initially of trying to contain the spread of the virus once it had entered the UK/Wales, followed by plans to delay its spread and to prepare the system

for cases. My primary concern at this point was on the nursing workforce. The signs were that there would be a rapid increase in cases once the infection gained a foothold in Wales and as a consequence, we would quickly need to increase the bed availability for infected patients, which would require relocating and retraining staff to work in areas unfamiliar to them, increase the number of staff able to give direct care, bearing in mind that staff too would become ill, and we would need to manage the impact of reduced supervision of students in training whilst on clinical placement. One of my early actions in this regard was to send a letter dated 24 March 2020 to the Nurse Directors explaining to them how to apply the Nurse Staffing Levels (Wales) Act 2016 to adult in-patient wards, which I produce as exhibit **M2B.CNO.JW.01/021-INQ000080902.** This had been agreed by the Minister for Health and Social Services, along with the revised timetable to extend the provisions of the Act to paediatric in-patient areas. I produce here, as exhibits **M2B.CNO.JW.01/022–INQ000116606** and **M2B.CNO.JW.01/023–INQ000299029**, my advice to the Minister for Health and Social Services on Covid-19 disruption to the Nurse Staffing (Wales) Act (MA/VG/0994/20) and the Minister's response to that advice.

31. I used the regular meetings with the Nurse Directors to monitor how the Nurse Staffing Levels (Wales) Act was being implemented as there was no relaxation of reporting compliance during the pandemic. Minutes of the meeting held on 12 May 2020 illustrates this and I produce these here, as exhibit **M2B.CNO.JW.01/024-INQ000299276.**

32. A Covid-19 systems risk framework ("the Risk Framework") with actions for the health and social care sectors was developed by the Department of Health and Social Services Delivery and Performance Team led by Samia Saaed-Edmunds and shared with Directors for comment. I was able to contribute my professional view before it was sent to the Minister for Health and Social Services for approval. I was in agreement with the actions outlined, though I remained anxious about the workforce pressures we were going to experience. I do not recall what was said about the evidence base used in the development of the framework, as I was not involved in that stage of production. I produce here, as exhibit **M2B.CNO.JW.01/025–INQ000144856**, the ministerial advice on the Risk Framework (MA/VG/1004/20). The underlying premise of the Risk Framework was to ensure system readiness, with specific thought given to protecting vulnerable groups of people, to release and reconfigure capacity in health and social care, and to rest and retrain staff who would need to be redeployed. The Risk Framework consisted of 24 actions, 10 of which were announced in a written statement

on 13 March 2020, which I produce here as exhibit **M2B.CNO.JW.01/026–INQ000226942**. The remaining 14 actions were set out in a further written statement later that week, which I produce here as exhibit **M2B.CNO.JW.01/027–INQ000300089.**

33. My understanding of the term 'herd immunity', which predates the Covid-19 pandemic, is that population immunity from an infectious disease can be gained through vaccination or when sufficient percentage of the population has gained natural immunity through overcoming the disease in question. In the latter situation, natural immunity helps populations have resilience when faced with new outbreaks of the disease. Immunity through vaccination and natural immunity tends to wane over time. I do not recall this matter being discussed at EDT Meetings in the January-March 2020 period and the minutes do not mention it. I was not involved in the provision of any advice or the taking of any decisions regarding adopting or rejecting policies that relied on herd immunity. However, I would not expect to have been involved in any such discussions (if any in fact took place) as they were outside my professional expertise, and for this reason I am also unable to offer a professional opinion on any decisions that were taken.

34. I was not directly involved in providing any advice, or taking any decisions, regarding moving Wales into a period of lockdown outside the discussions held at the weekly EDT Meetings with the Director General, HSS (see paragraphs 21 and 22 of this statement, and the documents there exhibited). Based on the information shared with me during those meetings, I was happy to support the decision to lockdown as a means to limit the spread of virus and reduce the incidence of illness and death in the population. However, I do not have the professional competence to provide an opinion on whether these decisions were appropriate, including in respect of their timeliness, or the duration of the lockdown.

35. I was not involved in providing any advice, or taking any decisions, regarding restrictions imposed on international travel or border controls. I do not have the competence to comment professionally on the decisions that were taken by others.

36. My understanding and recollections are that Welsh Government officials were involved with SAGE, based on my discussions with colleagues who did attend these meetings, e.g., Dr Rob Orford, Chief Scientific Adviser for Health (Wales), who had joined SAGE in February 2020. I recall information being fed from SAGE to the groups that I sat on,

primary among which was the Nosocomial Transmission Group (described in more detail in paragraphs 89 to 92 of this statement. I was not personally involved in any meetings with SAGE.

37. At the beginning of the pandemic Wales did not have its own modelling processes and instead we used a simple population proportion approach from English or UK models, e.g., those developed by Imperial College London. However, in June 2020, a policy modelling group was set up as a subgroup of the Technical Advisory Cell led by Dr Orford, to develop models specifically for Wales. This modelling subgroup was led by Dr Brendan Collins and Craiger Solomons and was supported by Public Health Wales and the London School of Tropical Medicine and Hygiene. This group pulled in the work of researchers at Swansea University, and some other academics. The first modelling report was published on 7 May 2020. These reports were published on the Welsh Government's website.[1] The Technical Advisory Cell ("TAC") therefore received more detailed modelling that it shared with EDT, Ministers and NHS Wales Chief Executives and other system planners. Briefings usually included 'most likely scenario' and 'worst case scenario' and as time went by, we were able to overlay the model predictions with actual Covid-19 infections, mortality and hospital admissions. I saw these model predictions at the various meetings I attended and found them to be most useful. In June 2022, the TAC undertook a retrospective review of the Covid-19 modelling work it was involved with, which I produce here as exhibit **M2B.CNO.JW.01/028–INQ000300019**.

38. As far as I can recall, I believe the actions taken by the Welsh Government in the initial phase generally aligned with those taken by the UK Government.

**Actions I took within my team during the initial phase of the pandemic response**

39. I joined the other UK Chief Nursing Officers, Ruth May, the Chief Nursing Officer for England, Fiona McQueen, the Chief Nursing Officer for Scotland, and Charlotte McArdle, the Chief Nursing Officer for Northern Ireland ("the UK CNOs"), to work with the Nursing and Midwifery Council to make changes to the education standards that modified the training of pre-registration nursing and midwifery students and created a temporary register for specific groups of staff, including recently retired staff who wished to return to practise. The first such virtual meeting took place on 12 March

[1] https://www.gov.wales/technical-advisory-group-modelling-updates-and-subject-specific-reports

2020, and I produce here as exhibit **M2B.CNO.JW.01/029–INQ000300090**, the minutes of that meeting. Karen Jewell, Midwifery Officer, Paul Labourne and Gill Knight, Nursing Officers were involved in the numerous meetings. Health Education and Improvement Wales ("HEIW"), which is the strategic workforce body for NHS Wales and commissions professional health education on behalf of Welsh Government, officers played a significant role in implementing the changes to standards via the Council of Deans Wales. I explain this process in more detail in paragraph 63 of this statement.

40. All directors within the Health and Social Services Group met weekly prior to the Covid-19 pandemic to discuss issues affecting the planning and delivery of health and social care services, finance, ministerial priorities, press coverage, and future strategic direction. Meetings were led by the Director General, HSS. Once it became clear that Wales was facing a public health emergency, caused by the Covid-19 virus, these meetings were supplemented from 16 March 2020 by daily virtual meetings to address any emerging urgent issues. I produce here as exhibit **M2B.CNO.JW.01/030–INQ000300091** the draft minutes of those daily virtual meetings.

41. I also began moving my team to a virtual, home-based working model during the week commencing 16 March 2020, ahead of the Welsh national lockdown commencing on 23 March 2020. All staff members had the ability to work remotely as all had laptops. This was in line with the decision taken by the Permanent Secretary to reduce the risk to staff by minimising attendance at offices and the use of public transport during the country-wide lockdown.

42. The decision to formally move all Welsh Government staff to a virtual working arrangement, bar certain essential staff needed to run specific services or who needed to access the building for well-being reasons, was implemented on 25 March 2020 (the minutes of the EDT Meeting on 25 March 2020 where this was discussed are exhibited at paragraph 26 of this statement, as exhibit **M2B.CNO.JW.01/017–INQ000300087**.

43. From week commencing 16 March 2020 onwards, I started holding twice weekly, 30-40 minutes virtual meetings (on Wednesdays and Fridays) with the Nurse Directors. The purpose of these meetings was to share information and be alerted to specific service issues that may require a Welsh Government response. See exhibit **M2B.CNO.JW.01/019–INQ000299025**, exhibited at paragraph 29 of this statement.

44. During this same period, in early to mid-March 2020, I determined that some of my staff should be redeployed to support the response to the public health emergency.

45. I sent the executive officer from the maternity team to support the Covid-19 Test, Trace and Protect policy team. She did not return to my team and remained in a supporting role throughout the pandemic.

46. The higher executive officer who had been working on the extension of the Nurse Staffing Levels (Wales) Act 2016 went to work first in the health emergency call centre, then on the review of mass deaths provision, and finally to support the public health resilience team. He returned to my directorate in August 2020 to complete the work required to enable the expansion of the Nurse Staffing Levels (Wales) Act (2016) to paediatric wards, as this was a Welsh Government manifesto commitment. Options were kept under review to see whether the planned preparatory work and public consultation could be undertaken during the pandemic. A revised timetable for the work leading up to the extension of the Act was agreed by the Minister for Health and Social Services on 19 March 2020. See exhibits **M2B.CNO.JW.01/022–INQ000116606** and **M2B.CNO.JW.01/023–INQ000299029**, exhibited at paragraph 30 of this statement. The work was undertaken as set out in the revised timetable and the Act was successfully extended to cover paediatric inpatient areas in February 2021 and came into force on 1 October 2021.

47. The Improving Lives programme, through which the Welsh Government intended to deliver policy changes for people with learning disabilities was paused for six months with the agreement of the Minister for Health and Social Services and the Deputy Minister for Social Services. Work on the Improving Lives Programme stopped on 20 March 2020 and restarted on 1 October 2020, with a focus on elements that related to addressing challenges posed by the pandemic. I produce here my briefing to the Deputy Minister for Social Services on restarting the Learning Disability Programme, as exhibit **M2B.CNO.JW.01/031–INQ000300029,** and the Deputy Minister for Social Services' approval, as exhibit **M2B.CNO.JW.01/032–INQ000299584.** One of the three staff members who had been working on this programme in March 2020, was sent to support the Chief Scientific Adviser for Health's Technical Advisory Cell work and remained there even after the Learning Disability Improving Lives programme re-started. The remaining two staff members continued to support Hazel Powell, nursing officer, in addressing immediate health issues relating to people with learning

disabilities due to the pandemic and liaised with service managers and the civil servants in the Social Services Directorate.

48. A number of advisory cells were also established. These were led by Welsh Government officials, but they interacted with NHS Wales, social care commissioners and other agencies as required. I and my nursing officers all contributed to different cells and groups, related to the roles we had described in the following paragraphs.

49. I became a member of the NHS Planning and Response Cell, chaired by Samia Saeed-Edmonds, Planning Programme Director, Welsh Government Planning and Delivery Directorate, in March 2020. This cell had been established during the week commencing 24 February 2020 with NHS planners and corporate operational managers, for the purpose of considering the day-to-day impact of the pandemic on NHS service delivery, and it helped to advise the Welsh Ministers on areas where decisions were needed. I produce here, as exhibit **M2B.CNO.JW.01/033–INQ000298988**, the terms of reference of the NHS Planning and Response Cell.

50. I asked Paul Labourne, nursing officer for out of hospital care, to head up a Primary and Community Care Covid-19 Cell, with Dr Liam Taylor, a GP, to coordinate primary and community services responses. I produce here as exhibit **M2B.CNO.JW.01/034–INQ000298997**, the terms of reference of the Primary and Community Care Covid-19 Cell. A paper was presented to EDT on 10 June 2020 that described the impact of Covid-19 on the delivery of community and primary care nursing services. It was agreed by the EDT that the Minister for Health and Social Services should be asked to fund a national nursing lead for primary and community care. I produce here as exhibits **M2B.CNO.JW.01/035–INQ000300092**, **M2B.CNO.JW.01/036–INQ000300093** and **M2B.CNO.JW.01/037–INQ000299376**, the minutes of the EDT meeting on 10 June 2020, the ministerial advice submitted to the MHSS (MA/VG/1746/20), and the Minister's response to that advice, respectively. The Primary and Community Care Covid-19 Cell developed the proposal that asked for this post to be established to help with the response to Covid-19 in primary and community care and delivery of the pathway they had developed. It was agreed to appoint an individual for a two-year period, and then review effectiveness. Chiquita Cusens was appointed to this post in early 2021, reporting to the national director and strategic lead for primary care and to the CNO(W). The appointment is hosted by Aneurin Bevan University Health Board and is still current.

51. Karen Jewell, midwifery officer, also set up regular meetings with the NHS Wales Heads of Midwifery Services, Health Visiting Services, Community Children's Nursing Services and School Nursing Services. The primary purpose of these meetings was to provide forums for information sharing and were mainly focussed on operational issues that affected service delivery.

52. I asked Gillian Knight, nursing officer, to support the First Minister's Black and Minority Ethic Covid-19 Advisory Group, chaired by Professor Keshav Singhal and Helen Arthur, Director of the Workforce & Organisational Development Directorate. This group was established on 29 April 2020, and I produce here as exhibit **M2B.CNO.JW.01/038–INQ000271615,** the terms of reference of the First Minister's Black and Minority Ethnic Covid-19 Advisory Group. This group issued its first guidance after two weeks of work and issued the Covid-19 workforce risk assessment tool for use within NHS Wales and with social services staff on 27 May 2020. I produce here, as Exhibit **M2B.CNO.JW.01/039–INQ000299409**, the Covid-19 workforce risk assessment tool.

53. I also asked Gillian Knight to join the Workforce Deployment and Wellbeing Cell, led by the Workforce and Organisational Development Directorate. This cell dealt with issues such as terms and conditions of staff redeployed or on the temporary professional registers established to bring retirees back to practise. I produce here, as exhibit **M2B.CNO.JW.01/040–INQ000300094,** the terms of reference for this Cell.

54. I jointly chaired the Nosocomial Transmission Covid-19 Group ("NTG") with Dr Chris Jones, the Deputy Chief Medical Officer for Wales ("DCMO(W)"). This group had wide health and social care membership and produced a range of guidance and advice for NHS and social care settings. Gareth Howells, nursing officer, played a significant role via this cell, working with Nurse Directors and officers in Public Health Wales. This programme was established on 19 May 2020, and met fortnightly. I describe the work of the NTG in more detail in paragraphs 89 to 92 of this statement.

55. I had some involvement with the Covid-19 Moral and Ethical Advisory Group Wales ("CMEAG"), led by Dr Heather Payne, which was established to look at the ethical values and principles that should underpin the work of health professionals during the Covid-19 pandemic. I produce here the written statement made by the Minister for Health and Social Services, the Minister for Housing and Local Government, and the

Deputy Minister and Chief Whip on the work of CMEAG, as exhibit **M2B.CNO.JW.01/041–INQ000227094.**

56. I also joined the virtual meetings of the UK Governments' senior clinicians, chaired by the Chief Medical Officer for England ("CMO(E)"). All four UK CNOs were invited to join this group after it had been running for some months, as it was felt we could offer a useful professional perspective. Initially, we met on two evenings every week, and meetings later moved to once a week. This group shared the latest scientific advances to help understanding and ensure a consistent UK approach across devolved administrations, where possible. In hindsight, I think the four UK CNOs should have been present from the beginning, when this group was established. Notes of the meetings were kept by the CMO(E).

**Key decisions and advice**

*Hospital and hospice visiting*

57. One of the more significant policy areas in which I played a role during the pandemic was hospital and hospice visiting. I set out immediately below a chronology of the guidance issued by me during the pandemic on the issue of hospital and hospice visiting, and thereafter explain this advice in more detail.

57.1. 25 March 2020: Letter from the CNO(W) to NHS Wales chief executives and Nurse Directors introducing restrictions on visitors with immediate effect, which I produce here as exhibit **M2B.CNO.JW.01/020-INQ000299068**

57.2. 20 April 2020: Letter from the CNO(W) to NHS Wales chief executives and Nurse Directors amending the restrictions with immediate effect, which I produce here as exhibit **M2B.CNO.JW.01/043–INQ000299228.**

57.3. 15 July 2020: Letter from the CNO(W) to chief executives, Nurse Directors and heads of midwifery in NHS Wales providing greater flexibility to local health boards and NHS trusts with effect from 20 July 2020, which I produce here as exhibit **M2B.CNO.JW.01/044–INQ000299515** together with an accompanying annex called "Hospital Visiting during Coronavirus Outbreak: Guidance", which I produce here as exhibit **M2B.CNO.JW.01/045–INQ000300095**.

57.4. 13 November 2020: Letter from the CNO(W) to chief executives, executive directors of nursing, directors of therapies and healthcare scientists, NHS clinical directors, heads of midwifery, heads of sonography/radiotherapy services, and hospices in Wales, updating the instructions issued in July 2020 and adding a methodology for risk assessment with effect from 30 November 2020. I produce here, as exhibit **M2B.CNO.JW.01/046–INQ000299694**, a copy of the letter, and as exhibit **M2B.CNO.JW.01/047–INQ000081643**, a copy of the risk assessment.

The Minister made a statement on 30 November 2020 to alert Members of the Senedd and the public to the most recent changes to the guidance, which I produce here as exhibit **M2B.CNO.JW.01/048–INQ000300096.**

58. When I first issued guidance to the NHS on 25 March 2020, I said that the guidance would be kept under review as the outbreak progressed. Initially the guidance was Welsh Government led, and directed to chief executives and Nurse Directors in NHS Wales, to ensure an immediate system-wide approach that was aligned with the other lockdown restrictions being put in place across Wales. My primary concern at that time was in preventing cross infection and protecting patients, staff and visitors. The initial guidance restricted visiting to all adult inpatients not infected by the Covid-19 virus, with three exceptions: permitting one parent or guardian to be with a paediatric or neonatal in-patient; women in labour to have one birthing partner from their household; and patients receiving end of life care, with the advance agreement of the ward sister/ward manager, to have one visitor for an agreed amount of time. Visiting to patients with the Covid-19 infection was to be permitted in exceptional circumstances only.

59. On 8 April 2020, changes were introduced into the NHS England hospital visiting guidance, which I produce here as exhibit **M2B.CNO.JW.01/049–INQ000300097**. They had added one additional situation to the three exceptions to restricting visiting to non-Covid-19 patients. The following addition was made: "*someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient/service user to be distressed*". This seemed an important addition to make to the guidance in Wales too and, therefore, I issued an update to the guidance on 20 April 2020. I reiterated in my letter that wherever possible family members and loved ones were to be enabled to say goodbye to Covid-19 infected patients receiving end of life care. I remained acutely aware of the impact this was

having on patients and their families and loved ones, but I remained of the opinion that in the absence of a vaccine, minimising the risk of cross infection was paramount.

60. After the initial peak of Covid-19 infections had subsided, Wales entered a period of sustained transmission within the population. At this point it seemed important to move to an approach than enabled local health boards and Velindre University NHS Trust to make more local decisions based on a set of principles that emphasised a person-centred, flexible approach. The revised guidance issued on 15 July 2020, which came into force on 20 July 2020, had been developed in consultation with representatives from NHS Wales and had been reviewed by the NTG. The principles still had at the forefront the need to protect patients, staff and visitors from the risk of contracting the virus, but it also balanced the need to enable visiting with a purpose in a variety of clinical settings as far as it was safe to do so. The guidance encouraged the use of virtual contact where it wasn't safe for in-person visiting to take place.

61. The July 2020 guidance had an annex 2 that set out specific considerations for pregnant women and their partners visiting maternity services, including the antenatal scans and checks done at: 12 weeks pregnancy dating scan, early pregnancy clinic, anomaly scan, and attendance at a Fetal Medicine Department. This guidance had been developed following multiple correspondences from the public and Members of the Senedd, on behalf of their constituents, strongly requesting that partners should be present with the pregnant woman. After this guidance was issued, I received feedback from the sonographers and radiographers, who undertake the antenatal scans, raising concerns about the practical application of this guidance to their physical environments. Their concerns were that the rooms used for scans are typically small with limited ventilation, and consequently maintaining 2 metres distance from anyone accompanying the pregnant woman would be impossible. Additionally, waiting rooms could easily become full if additional people attended with the pregnant woman, again making social distancing difficult. They also did not feel they had been consulted sufficiently before this new guidance was issued. I held a meeting with representatives on 5 August 2020 to agree a way forward, and I produce here the minutes of this meeting as exhibit **M2B.CNO.JW.01/050–INQ000300098**. It was agreed that a risk-based approach would be applied locally in order to ensure everyone's safety.

62. During the autumn months the infection rates again began to increase within communities in Wales, leading to a two-week firebreak lockdown from 23 October to 9 November 2020. When the First Minister announced this lockdown, he also said that

there would be a new simpler set of rules from 9 November 2020 onwards, set out under the Health Protection (Coronavirus Restrictions) (Number 4) (Wales) Regulations 2020. Even with increasing community transmission it was still felt important to allow NHS organisations to have flexibility in determining who had access to their premises. Everyone was aware of the negative impact restricting visiting was having on in-patients and therefore no one wished to increase restrictions unless it was deemed essential in specific clinical areas to do so. As a consequence, a further revision of the national guidance for hospital visiting was undertaken that was issued on 13 November 2020 and came into force on 30 November 2020. This guidance made reference to the risk-based approach, agreed with the radiographers and sonographers in NHS Wales, that was being applied locally to support pregnant women throughout their pregnancy journey. The guidance also provided a weblink to the joint Royal College of Obstetricians and Gynaecologists and Royal College of Midwives guidance "Reintroduction of visitors to maternity units across the UK during the Covid-19 pandemic" issued on 8 September 2020, to assist in understanding how a risk assessed approach to visiting could be undertaken. The November 2020 guidance was accompanied by a written statement by the Minister for Health and Social Services that described the approach being implemented. It was felt this was important to do given the number of letters of concern that had been made by the public and some sections of the health service asking for changes or information. The guidance was published on the Welsh Government's website.

*Education standards for nurses and midwives*

63. The education standards that govern the education of nurses and midwives are set by the Nursing and Midwifery Council (NMC), the UK professional regulator. These standards apply to all four countries of the UK because health professional regulation is reserved. At the beginning of the pandemic the UK CNOs along with the NMC worked closely together to make changes to the education standards and established arrangements to create a temporary register for nurses and midwives who wished to return to work as registrants to support the UK NHS and social care systems. I set out below a chronology of the key milestones in the modification of these standards in response to the Covid-19 pandemic: -

63.1. The first meeting between the NMC, the UK CNOs, and other agencies took place on 12 March 2020. I produce here, as exhibit **M2B.CNO.JW.01/029–INQ000300090**, the minutes of that meeting.

63.2. On 21 March 2020, a joint statement by the CMO(W), the CNO(W) and the Deputy Director General of Social Services and Integration was prepared and issued, encouraging retirees (up to three years post leaving the professional registers) to return to help. This covered health and social care workers. I produce here a copy of this joint statement, as exhibit **M2B.CNO.JW.01/052–INQ000300044**.

63.3. On 23 March 2020, the Minister for Health and Social Services was asked to agree to the issuing of a joint statement by the NMC and UK CNOs on changes to the education standards for first, second, and third-years student nurses and midwives. I produce here, as exhibit **M2B.CNO.JW.01/053–INQ000299111**, a copy of the joint statement, and as exhibit **M2B.CNO.JW.01/054–INQ000299110**, a copy of my correspondence with the Minister regarding the statement.

64. Following the introduction of the NMC emergency standards, in late March Health Education and Improvement Wales wrote to all postgraduate and undergraduate nursing and midwifery students enclosing guidance for students developed by HEIW and Welsh Government explaining the impact for them, depending on the stage of their education, namely: -

64.1. Students in their first year of the undergraduate programme were advised that they would continue with their nursing and midwifery programme. Their clinical placements were paused, and for the duration of the emergency they continued their academic work.

64.2. Students in the second year or the first six months of the final year of their undergraduate programme, and postgraduate pre-registration students not in the last 6 months of their programme, were advised that it was not possible to continue to provide the current programme. These students were invited to opt-in to an arrangement to spend 80 percent of their time in clinical practice, remunerated (band 3) (which would count towards their practice hours as it would form part of the student's programme), and 20 percent in academic study

during this emergency period. The purpose of the period of academic study was to build in designated, structured, regular contact with their Approved Education Institutions (AEI). AEIs maintained academic and pastoral support throughout the programme, wherever the student was situated, during the emergency situation.

64.3. Students in the last six months of their education programme could opt into an extended placement and undertake the final six months of their programme as a clinical placement, remunerated at band 4. I produce here, as exhibit **M2B.CNO.JW.01/055–INQ000300099**, a copy of this letter.

65. Welsh Government officials worked with key stakeholders to develop appropriate deployment guidance for employers, professionals and students which included the terms and conditions and remuneration for students working in clinical practice. The durations of contracts were: six months for third year students in the last six months of training; and three months for second year students and third year students in the first six months of their final year. These contracts were payable from 27 April 2020.

66. The Welsh Government, in partnership with NHS Wales Shared Services Partnership and GP Wales, developed Covid-Hub Wales as an end-to-end recruitment solution for all health boards' temporary workforce needs through the Covid-19 pandemic. Covid-Hub Wales provided support for health boards' targeted recruitment campaigns for a range of clinical and non-clinical roles. It also supported individuals to make a speculative application to register their interest by completing their profile, including the health boards/trusts and the settings they would be prepared to work in.

67. The Welsh Government ensured students were able to benefit from 'Death in Service' indemnity cover whilst on clinical placements.

68. The Nursing and Midwifery Council was given permission by the UK Government to establish a Covid-19 temporary register, that went live on 27 March 2020. This temporary register enabled those nurses and midwives who had left the register in last three years to return to practise.

69. On 2 April 2020, I provide advice to the Minister in respect of an extension of the Covid-19 temporary register to overseas nurses and midwives who had completed all elements required for registration except the Objective Structured Clinical Examination

(OSCE); and those who had left the register 4-5 years ago. A joint statement was issued with Ministerial approval. I produce here my advice to the Minister, as exhibit **M2B.CNO.JW.01/056–INQ000226982**; the Minister's approval of that advice, as exhibit **M2B.CNO.JW.01/057–INQ000299092**; and the joint statement, as exhibit **M2B.CNO.JW.01/058–INQ000300100.**

70. On 29 June 2020, the Minister for Health and Social Services published a written statement explaining that the three and six-month contracts given to student nurses and midwives which enabled payment for their clinical work during the pandemic would not be extended beyond the original time agreed for the contracts. The reason for not extending paid contracted work as healthcare support workers was that there were concerns that students would not have the opportunity to complete their programmes on time in order to enter the professional register and subsequent employment as a fully registered nurse. I produce here, as exhibit **M2B.CNO.JW.01/059–INQ000300021**, a copy of that written statement.

71. On 10 July 2020, the Minister for Health and Social Services was provided with an update on the nursing and midwifery programmes indicating that the NMC, with agreement from all four UK nations, would stop the emergency education standards introduced in the first wave of the pandemic on 30 September 2020. This briefing indicated that 90% of the 3rd year students would graduate on time with a maximum of delay for some students of up to 7 weeks. I produce, here as exhibit **M2B.CNO.JW.01/060-INQ000300101**, a copy of that update.

72. On 4 January 2021, the Minister for Health and Social Services was informed of the Nursing and Midwifery Council's intention to further extend the criteria for overseas trained nurses to join the Covid-19 temporary register, with effect from 6 January 2021. He agreed to their issuing a high-level statement. There were some overseas nurses (estimated 100-130) who would benefit from these changes. I produce here, as exhibit **M2B.CNO.JW.01/061–INQ000300102**, a copy of that statement.

73. On 13 January 2021 I alerted the Minister for Health and Social Services to the letter sent by Matt Hancock, Secretary of State for Health to the Chief Executive of the Nursing and Midwifery Council requesting the reactivation of the emergency standards brought in during the first wave of the pandemic, and later withdrawn in summer 2020. If reactivated, it would enable 3rd year nursing students to undertake a 12-week paid placement rather than have the normal supernumerary status that facilitated their

clinical learning. My advice to the Minister was to note this request but that mobilising the 3rd year students in such a way was not deemed necessary for the delivery of care in Wales at that time. I reminded him that students who wished to undertake paid employment in NHS Wales on top of their studies were enabled to do so through the Nursing Bank system. I produce here, as exhibits **M2B.CNO.JW.01/062–INQ000300103** and **M2B.CNO.JW.01/063–INQ000299754** respectively, the letter from the Secretary of State to the Chief Executive of the NMC, and my advice to the Minister.

74. On 10 February 2021 a written statement was issued by the Minister for Health and Social Services in respect of not deploying 3rd year nursing students into rostered/paid employment. A briefing note was also sent to the Chair of the Senedd Health and Social Care Committee for noting, setting out the rationale for this decision. I produce here as exhibits **M2B.CNO.JW.01/064–INQ000300104** and **M2B.CNO.JW.01/065–INQ000299780** respectively, the written statement issued by the MHSS, and the briefing note provided to the Senedd Health and Social Care Committee.

75. The higher education programmes for nurses and midwives that prepared them for registration as Specialist Community Public Health Nurses (Registered SCPHN) and programmes that led to specialist community qualifications, such as district nurses, were temporarily paused to allow the deployment of staff to clinical areas. In the meeting with Nurse Directors on 5 May 2020, Stephen Griffiths, Director from Health Education and Improvement Wales, informed the Nurse Directors of the restarting of the programmes to enable staff to qualify either in 2020, or early 2021. I produce here the minutes of that meeting, as exhibit **M2B.CNO.JW.01/066–INQ000299268**.

*Staffing ratios*

76. One of the challenges the NHS faced was in expanding its critical care services to meet the increased demands of very sick patients due to the Covid-19 pandemic. Expansion required more equipment, such as ventilators and Continuous Positive Air Pressure (CPAP) machines (CPAP work by pressurising the air that is delivered through a hose and mask. The steady flow of air keeps the airway open and improves respiration), and crucially more staff. However, it was not just a simple matter of deploying staff from another area to work in the intensive care and high dependency units due to the specialist highly technical nature of the work. Normal pre-pandemic practice in intensive care was for one trained critical care nurse per level 3 patient with

additional senior nurse oversight of the unit; and one critical care trained nurse for two level 2 patients again with senior nurse oversight in the unit. Level 3 intensive care units take critically ill patients requiring mechanical ventilation, advanced monitoring, and specialised physician and nursing care. Level 2 intensive care unit patients require close cardiac monitoring and nursing observation. Decisions were therefore needed to determine the degree to which the critical care trained nurse to patient ratio could be increased safely, with the involvement of other redeployed staff.

77. A joint statement was made on 25 March 2020 by the UK CNOs, trades unions, and the following professional groups: UK Critical Care Nursing Alliance, CC3N British Association of Critical Care Nurses Intensive Care Society, RCN Critical Care Forum, and National Outreach Forum. This statement explained our collective view on the need for a different way of staffing critical care settings and the need for a team-based approach to be introduced. I produce here, as exhibit **M2B.CNO.JW.01/067–INQ000227427** that joint statement. I shared the guidance that emerged from the expert clinical group - The UK Critical Care Nursing Alliance – that provided options for changes in staffing ratios with Welsh Government policy lead that dealt with the Wales Critical Care and Trauma Network. This network considered this guidance and applied what they considered appropriate for NHS Wales' critical care settings. I believe the result of this was to allow some changes to the staff patient ratios in the intensive care units across Wales. I recall being told that during the height of demand one intensive care nurse was overseeing the care of two level 3 patients with the support of another health professional. I think the maximum number of level 3 patients any trained intensive care nurse could be asked to look after was three, with other health professionals in a supporting role, but that this ratio was not routinely required. I also shared the information with the Nurse Directors, to draw their attention to the position being advocated to help them with local decision making on staffing. I further shared updates from the UK Critical Care Nursing Alliance when published in November 2020 and January 2021 with the same individuals.

78. Field hospitals in Wales were open and utilised consistently from October 2020. I discussed and agreed the staffing model being adopted with the Nurse Directors. The predominant model used across Wales was a 'step-down' service, which used a multi-professional and integrated team approach that facilitated the handover of care back to the community. This enabled provision of additional and often much needed rehabilitation to patients. Additional staff training was instrumental in enabling field hospitals to function well and empowered excellent working relationships across local

teams to develop, including the integration of therapy staff into the clinical teams. Some health boards redeployed nurses with a mental health background to the sites, and reported this had worked very well, especially in supporting patients who had cognitive impairment.

*Moral and ethical decision making*

79. On 12 April 2020, the Chief Medical Officer and I issued a joint letter to NHS Wales informing them of the publication of a new framework of values and principles for healthcare delivery in Wales, to provide guidance for healthcare services when making decisions during the coronavirus outbreak that arose from the work of this group. I produce here a copy of my letter with the CMO, as exhibit **M2B.CNO.JW.01/068–INQ000300105** and a copy of the framework, as exhibit **M2B.CNO.JW.01/069–INQ000081000.**

80. The CMO(W) and I issued further guidance on 17 April 2020 reminding clinicians that Do Not Attempt Cardiopulmonary Resuscitate ("DNACPR") decisions must be made on an individual basis. Age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes. I produce here, as Exhibit **M2B.CNO.JW.01/070–INQ000300106**, a copy of that letter.

*Uniforms*

81. I issued advice to bodies in the Welsh NHS at the beginning of April 2020, to explain what staff should do in respect of wearing and laundering their uniforms during the Covid-19 pandemic. I produce this email here, as exhibit **M2B.CNO.JW.01/071–INQ000299158**, together with NHS England's guidance for NHS employers on uniforms and workwear, as exhibit **M2B.CNO.JW.01/072–INQ000299162**; an NHS England alert on scrubs, gowns, alginate bags and linen cages, as **Exhibit M2B.CNO.JW.01/073–INQ000299161**; and Public Health Wales's recommendations for wearing and laundering of healthcare staff uniforms during the Covid-19 pandemic response, as exhibit **M2B.CNO.JW.01/074–INQ000299163**. The Welsh Government did receive correspondence from members of the public who were concerned about seeing people in uniform in the community, though it was not clear who these staff were. I reinforced my message about ensuring appropriate staff behaviour in respect of wearing their uniforms with the Nurse Directors at our meeting on 14 May 2020. I

produce here the minutes of that meeting, as exhibit **M2B.CNO.JW.01/075–INQ000299164**.

*Use of virtual technology in nursing*

82. At the end of May 2020, my team issued revised guidance to health visiting services in Wales, based on the Institute of Health Visiting's 'First Birth Visit' guidance. This new guidance promoted the use of virtual technology and built on the previously issued Healthy Child Wales Programme guidance and Public Health Wales' document 'Parenting Give it Time'. I produce here the Welsh Government's guidance to health visiting services, as exhibit **M2B.CNO.JW.01/076–INQ000299943** and the Institute of Health Visiting's guidance, as exhibit **M2B.CNO.JW.01/077–INQ000300107.**

83. A request was made to the Minister for Health and Social Services on 1 February 2021 to approve £1,310,549 funding to provide health visitors, school nurses and community children's nurses with IT devices to support and enhance the provision of services during the pandemic. I produce here the ministerial advice, as exhibit **M2B.CNO.JW.01/078–INQ000145409**, and the Minister's response, as exhibit **M2B.CNO.JW.01/079–INQ000299768**.

*School nursing services & Community nursing services*

84. Following the Minister for Education's announcement that pupils would be returning to schools on 29 June 2020, I asked the Nurse Directors at our meeting on 9 June 2020 to make plans to stand up their school nursing services and return redeployed staff to their substantive roles. I produce here the minutes of that meeting, as exhibit **M2B.CNO.JW.01/080–INQ000299375**. This would prove to be difficult as many of the school nurses could not be released from their alternative roles immediately and therefore it took some time for normal support to be fully established. In the autumn term the school nursing services were again running, although there were still a small number of gaps due to some school nurses having not yet returned to their posts.

85. The joint operational heads of health visiting, and school nursing meetings continued bi-monthly throughout 2020, with reports submitted to my office's lead, Karen Jewell. It was important that the normal national screening and immunisation programmes be reintroduced as soon as possible. It was good to see operational solutions being

developed, e.g., mass vaccination, to ensure these programmes were offered in all schools. Some Health Boards also set up online contact arrangements, so that children had access to school nurses.

86. An approach called 'Care Closer to Home' was developed by the All-Wales Children Services Nurse Leads Forum and adopted across Wales by the end of 2020. Care Closer to Home teams, comprising community children nurses, support early discharge from hospital and hospital avoidance along identified pathways of care, where care can be managed safely at or closer to home. This approach is still in place across Wales and typically runs seven days a week and supports paediatric patient referrals within the following pathways:

86.1. Intravenous/Intra-muscular Antibiotics Pathway

86.2. Gastroenteritis Pathway

86.3. Respiratory Conditions Pathway

86.4. Wound Care Pathway

86.5. Urinary Tract Infection Pathway

86.6. Faecal dis-impaction Pathway

*Risk to people with learning disability and those living in supported accommodation*

87. I asked Hazel Powell and colleagues from Public Health Wales to prepare a paper highlighting the risk to people with learning disability and their carers from Covid-19, to inform the development of the UK vaccination policy and raise awareness of the vulnerability of this section of society. This paper was presented to the UK Senior Clinicians meeting 24 July 2020. Some members of the Senior Clinicians Group also sat on the Joint Committee on Vaccination and Immunisation ("JCVI"), which determines UK vaccination programmes. I was pleased to see that when the Green Book on immunisation for infectious disease, chapter 14a was published, which deals with Covid-19 vaccinations, table 3 on page 25 makes clear reference to prioritising for vaccination people with chronic neurological disease. It states, "*This group also includes individuals with cerebral palsy, severe or profound and multiple learning*

*disabilities (PMLD) including all those on the learning disability register, Down's syndrome...*" This paper was also shared at the EDT Meeting held on 5 August 2020 to support policy development. I produce here, as exhibit **M2B.CNO.JW.01/081-INQ000300108**, the paper on the risk Covid-19 posed to people with learning disability and their carers, as presented to the UK Senior Clinicians Group (please note the minutes of these meetings are held by CMO(E)); and as exhibit **M2B.CNO.JW.01/082–INQ000300109**, the minutes of the EDT meeting held on 5 August 2020.

88. I had a meeting with the Deputy Minister for Social Care on 15 July 2020 where she asked about testing vulnerable people who lived in supportive living accommodation, as there was now clear evidence of a higher risk of death from Covid-19 amongst this population than the general population. The Deputy Minister had reviewed the draft testing strategy for Wales (which I produce here as exhibit **M2B.CNO.JW.01/083–INQ000083244**) on 14 July 2020, in ministerial briefing MA/VG/2299/20 (which I produce here as exhibit **M2B.CNO.JW.01/084–INQ000136799**), and she felt that the issue was not sufficiently clearly addressed. Following the meeting I spoke with the policy lead, Jo-Anne Daniels, and the outcome was an addition to section 5 in the new testing strategy (published later that week) that explicitly referred to people in supportive living accommodation. I produce here, as exhibit **M2B.CNO.JW.01/085–INQ000300110**, a copy of the final testing strategy that was published on 15 July 2020.

**The work of the Nosocomial Transmission Group**

89. The Nosocomial Transmission Group ("NTG") was established on 19 May 2020. It was jointly chaired by the DCMO(W) and me, and I remained as joint chair until I retired in April 2021.

90. The purpose of the NTG was to provide advice, guidance and leadership on the actions needed to minimise the nosocomial (infection(s) acquired during the process of receiving health care that was not present at the time of admission) transmission of Covid-19, and to enable the safe resumption of routine services in health and social care settings. The work covered hospitals, primary and community care settings, prisons, registered care homes, domiciliary care, and learning disability units. The group developed and oversaw the implementation of infection prevention and control measures ("IPC"), including patient and staff isolation and testing. I produce here the terms of reference of the NTG, as exhibit **M2B.CNO.JW.01/086–INQ000271888.**

91. The NTG's work programme covered five key areas:

91.1. evidence based guidance

91.2. hygiene, distancing, and decontamination of health and care environments

91.3. leadership in IPC

91.4. awareness, education, and training in IPC; and

91.5. creating a culture where IPC is seen as everyone's business.

92. Membership was made up of the following:

92.1. Welsh Government officers (18 people): CNO(W), DCMO(W), nursing officers, senior medical officers, social services, the Chief Dental Officer, and policy leads for infection prevention, communicable disease control, quality and safety, population health, housing, and environmental health

92.2. Public Health Wales (3 people)

92.3. NHS Wales nurse and medical executives, the chair of the Healthcare Acquired Infection Advisory group, and senior medical clinician lead (5 officers)

92.4. Health Education and Improvement Wales

92.5. NHS Shared Services

92.6. a trade union representative from the NHS Wales Partnership Board; and

92.7. the Interim Chair of the Academy of Medical Royal Colleges.

93. The NTG's primary purpose was to develop operational guidance for health and social care services, but it also provided a forum that enabled issues to be identified from service representatives that helped shape the Welsh Government's thinking for further policy development. The NTG issued guidance on the following subjects: -

93.1. Guidance on the care of a deceased person who was positive for the Covid-19 virus, issued on 14 May 2020 (which I produce here as exhibit **M2B.CNO.JW.01/087–INQ000299100**). This guidance was endorsed by NTG but produced originally by Public Health England. The guidance sets out safe practice for handling the body of a person who was positive for the Covid-19 infection, as they remained a health risk to others. This included instructions for clinical staff who had been caring for the person (inside and outside hospital), through transport and housing in the mortuary, those supporting or involved in faith or belief practices, and transfer to funeral directors. The NTG wished to ensure the body was handled with respect, while at the same time ensuring the virus was not passed on to staff during the end stage of care.

93.2. Operational guide for the safe return of healthcare environments to routine arrangements following the initial Covid-19 response, issued on 3 June 2020 (which I produce here as exhibit **M2B.CNO.JW.01/088–INQ000299367**). This guidance provided practical guidance on areas such as signage, communication with staff and visitors, social distancing, infection control measures, adapting reception desks and waiting room areas, managing staff break out and canteen areas, managing administrative staff areas, and reminding organisations that any changes must be done with the agreement of the fire officer.

93.3. Covid-19 guidance on bed spacing in healthcare, issued on 26 June 2020 (which I produce here as exhibit **M2B.CNO.JW.01/089–INQ000299387**). I also wrote a follow up letter dated 17 August 2020 to clarify how the spacing was to be calculated, i.e., 3.6 metres from the centre of one bed to the centre of the next bed as this ensures a minimum 2 metre distance between the sides of the bed. I produce here that letter, as exhibit **M2B.CNO.JW.01/090–INQ000299553**). Developing a workable approach was discussed by NTG members. Issues included the impact of the bed space policy on how many beds could be physically contained in ward bays, which could in some circumstances result in an overall reduction in bed capacity if beds had to be removed from a bay area. Consideration was given to whether bed screens of different types could be used to mitigate the need to take beds out of areas, and whether the use of fans and other ventilation had a material impact on the airborne spread. Considering evidence from published sources was part of the decision-making process. Infection prevention experts within the group helped

determine the policy position on this. Concern about the impact of the policy on bed capacity was discussed with chiefs of operations via the Essential Services Cell, and NHS Wales chief executives. Consideration was also given to how these rules applied to the social care settings, as part of the decision-making process.

93.4. Operational guide for the safe return of general medical practice premises to routine arrangements following the initial Covid-19 response, issued on 1 July 2020 (which I produce here as exhibit **M2B.CNO.JW.01/091–INQ000299430**). This set out the principles to be used when reconfiguring premises to enable patients and staff to return safely and give people confidence when accessing services. It emphasised the importance of social distancing, face mask wearing, hand hygiene, and good signage.

93.5. Restricting the movement of bank, agency and locum staff was identified as important in stopping the transmission of Covid-19 within health settings. Guidance was issued on 10 July 2020, which I produce here as exhibit **M2B.CNO.JW.01/092–INQ000300111**. This guidance reminded managers about the need to cohort patients who were known to be positive or were suspected as being positive to the virus. It also reminded managers about the national infection prevention and control guidance, use of personal protective equipment (PPE), and the guidance on dealing with staff inadvertently exposed to the virus.

93.6. UK infection prevention and control revised guidance was issued on 2 September 2020. The guidance had been developed through a UK group, with representatives from Public Health Wales. It was reviewed by the NTG before being issued to service providers in Wales. At that time, the Welsh Government was not mandating the wearing of facemasks in non-clinical areas, and this was one area of notable divergence between Wales and other UK nations (including Scotland and England). There was some debate among public health advisers about the overall effectiveness of public mask wearing, e.g., poor fit over the nose and mouth, increased touching of the face with unclean hands, efficacy diminishing once the material became moist with breath, and people's unwillingness, for a variety of reasons, to wear them. Good and regular hand hygiene, coupled with 2 metres social distancing were seen as the more effective behaviours to insist upon. For this reason, the CNO(W) and

CMO(W) wrote a cover letter to health and social care providers which accompanied the revised UK IPC guidance, to explain how that guidance should be applied in social care settings. I produce here: the UK infection prevention and control revised guidance 2020, as exhibit **M2B.CNO.JW.01/093–INQ000299582**; the minutes of the NTG meeting on 28 August 2020 where this guidance was discussed, as exhibit **M2B.CNO.JW.01/094–INQ000300112**; the Welsh Government's guidance on the use of face masks in non-clinical settings then in force, as exhibit **M2B.CNO.JW.01/095–INQ000299379**; and the cover letter that I wrote with the CMO(W) to explain the approach in Wales and application of the UK guidance in Welsh care settings, as exhibit **M2B.CNO.JW.01/096–INQ000299567.**

93.7. Ahead of the annual autumn influenza vaccination programme and the planned Covid-19 round of vaccinations that coincided with this, a letter and guidance, referred to as an SBAR (Situation, Background, Assessment and Recommendation) report was issued to NHS Wales services from me and CMO(W). This guidance had been prepared by Gail Lusardi, Consultant Nurse in Infection Prevention and Control at Public Health Wales. The guidance included reference to PPE, infection prevention and control measures, safe disposal of waste, signage and communication with the public while in vaccination venues. I produce here, as exhibits **M2B.CNO.JW.01/097–INQ000300010** and **M2B.CNO.JW.01/098–INQ000300222**, the guidance on infection prevention and control in vaccination centres and the cover letter issued by myself and the CMO(W) respectively.

93.8. Operational guidance for the safe recovery of routine community group interventions (this was mainly mental health related services) following the initial Covid-19 response, issued in November 2020 (which I produce here as exhibit **M2B.CNO.JW.01/099–INQ000081502**).

93.9. A framework for testing patients for Covid-19 in hospitals, including community hospitals, hospices, mental health and learning disability inpatient settings, issued on 22 January 2021, in support of the revised strategy for testing people in Wales. I produce here the framework as exhibit **M2B.CNO.JW.01/100–INQ000299767.** The purpose of this framework was to prevent the virus entering, or being transmitted within, the health and care system. It covered

various situations: those being admitted for elective surgical care; protecting those following an emergency care pathway to prevent nosocomial transmission as far as possible; identifying patients who had recovered from Covid-19 and who were able to proceed with planned interventions; providing protection for patients in high-risk groups who may have other underlying medical conditions that made them vulnerable, e.g., patients undergoing renal dialysis or patients with cancer; and confirming non-infectivity prior to discharge e.g., to care homes.

94. A dedicated working group was established, under the leadership of Mandy Rayani, Executive Nurse Director of Hywel Dda University Health Board and Chair of the NHS working group on health care acquired infections ("HCAI"). This HCAI working group pre-dated the pandemic and reported directly to the Nurse Directors. However, it seemed sensible to build on existing structures and relationships, so the NTG working group on healthcare acquired Covid-19 drew upon the HCAI's existing structures and expertise. This working group revised the NHS cleaning standards in light of the Covid-19 outbreak. I produce here, as exhibit **M2B.CNO.JW.01/101–INQ000299708**, the revised NHS cleaning standards produced by the working group, and as exhibit **M2B.CNO.JW.01/102–INQ000300113**), the minutes of the NTG meeting where these standards were discussed. The revised cleaning standards and advice on ventilation in healthcare settings was issued by the Director-General in December 2020 to the NHS Chief Executives. This route was chosen due to the financial consequences identified with the new standards.

95. It was important that any lessons learned from NHS Wales were shared quickly to ensure good practice was promulgated across the system. To this end, the NHS Wales Delivery Unit established the Covid-19 Rapid Sharing of Early Learning platform at the behest of the NTG. A letter was sent to the Nurse Directors and executive medical directors advising them about this new platform on 6 August 2020, and I produce here this letter as exhibit **M2B.CNO.JW.01/103–INQ000300114,** and a copy of the platform as exhibit **M2B.CNO.JW.01/104–INQ000299502**. This platform did not require any changes to the reporting or investigation of in-hospital transmission of Covid-19 infections under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ("RIDDOR"), or the Welsh Government's no surprises and serious incidents reporting arrangements.

96. By October 2020, it became evident from the outbreak surveillance data reported to the NTG at each meeting by Public Health Wales, that there was a disconnection between the community rates of Covid-19 infection and the number and spread of infection seen in hospitals. This meant that hospital transmission was now an important and worrying factor in the rates of infections seen in Wales. Outbreaks in hospital wards meant that patients and staff needed to be isolated from other parts of the system, which caused operational challenges. Staff sickness, too, was an issue. Infection Prevention and Control (IPC) measures had an increased focus from here on. At the NTG meeting on 8 October 2020, it was reported that the Welsh Government would reintroduce weekly monitoring of outbreaks, to better inform the Ministers of what was happening in clinical environments and to support operational managers to address outbreaks effectively. This meeting also received a presentation on lessons learned from across NHS Wales on what worked well in managing outbreaks of infections in clinical areas. This was shared with all health boards and the Velindre University NHS Trust. I produce here the notes of the NTG meeting on 8 October 2020, as exhibit **M2B.CNO.JW.01/105–INQ000300115.**

97. It became evident over time that the no surprises and serious incidents reporting arrangements were burdensome, due to the volume of Covid-19 cases that needed to be reported. On 9 November 2020, instructions were sent to NHS Wales executives to streamline the system to ensure that cases were captured, and outbreaks were managed appropriately. A new form was issued that asked for a daily return of cases, their location, communication plans and outbreak management plan. This was sent to Public Health Wales and the Welsh Government Health Protection mailbox and copied to the co-chairs of the NTG. I produce here copies of the instructions, as exhibit **M2B.CNO.JW.01/106–INQ000300116**, and the reporting form, as exhibit **M2B.CNO.JW.01/107–INQ000300117**. In this way it became much easier for the NTG to monitor hospital outbreaks of the disease across the whole of NHS Wales because the information gave greater detail of where outbreaks were occurring, if they were being contained or not, and whether the interventions were working. This approach enabled us to identify good practice on outbreak management that was then shared with those who were finding it difficult to contain spread of the virus within clinical settings. The information gathered was shared with officials in the Welsh Government to support their response work.

98. Cardio-pulmonary resuscitation for people who experienced an acute cardiac or respiratory episode, both inside and outside a health care setting, was potentially risky

for anyone undertaking resuscitation if the collapsed person had Covid-19. In many situations the collapsed person's Covid–19 status was unknown. On 24 April 2020, the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") published its review on whether doing chest compressions and defibrillation constituted an aerosol generating procedure (APG) (which I produce here as exhibit **M2B.CNO.JW.01/108–INQ000300118**). NERVTAG concluded it did not pose a significant risk and advised that when developing clinical policy about what personal protective equipment staff should wear, to bear in mind the time it takes to don said equipment and the impact this may have on the likely success of the resuscitation.

99. On 28 April 2020, the Resuscitation Council UK provided guidance (which I produce here as exhibit **M2B.CNO.JW.01/109–INQ000300119**) that indicated that only chest compressions should be undertaken and that the collapsed persons mouth and nose should be covered by a cloth, because there was a potential of aerosol generation that would spread the virus. There appeared to be conflicts in the guidance produced by NERVTAG, and the Resuscitation Council UK guidance. The British Medical Association and the Royal College of Nursing challenged the assertions made by NERVTAG in respect of the potential level of risk to staff. Consequently, I observed in Wales differing approaches to clinical policies in the health boards and NHS trusts. This disagreement between bodies was escalated to the UK Senior Clinicians group, who decided that a new independent panel should be set up to look at high risk procedures such as chest compression in cardiopulmonary resuscitation, to determine the level of risk. It was called the Independent High Risk APG Panel. It was chaired by Professor Jacqui Reilly. The group held 11 meetings between 27 July 2020 and 12 April 2021. The CMO(W) and I issued a letter on 7 May 2020 to the medical and Nurse Directors to address how NHS Wales organisations should set local policy (which I produce here as exhibit **M2B.CNO.JW.01/110–INQ000299272**).

100. The NTG discussed potential routes of transmission at most meetings. One area the members of the NTG focussed on was the impact patients admitted to hospital had on the transmission of the Covid-19 infection within the hospital. Unfortunately, many patients admitted to hospital were symptom-free or were in the pre-symptomatic phase of the illness and therefore not exhibiting the signs of infection. The policy requiring testing of all hospital patients was issued on 15 July 2020 (which is exhibited as exhibit **M2B.CNO.JW.01/085–INQ000300110**, at paragraph 88 of this statement). This guidance built on the stipulation for testing all patients admitted to hospital previously set out in the guidance "A principles framework to assist the NHS in Wales to return

urgent and planned services in hospital settings", issued on 3 June 2020 (which I produce here as exhibit **M2B.CNO.JW.01/111–INQ000299363**). The DCMO(W) and I felt it necessary to issue a letter to NHS Wales directors on 22 September 2020, reminding them to follow this guidance in respect of all admissions, planned, urgent or emergency (which I produce here as exhibit **M2B.CNO.JW.01/112–INQ000299999**), as we remained concern about the introduction of infection from the community and the negative consequences this would have on our ability to deliver essential health services.

101. The NTG asked for a report from the independent sector who provided care to patients with mental health and learning disability needs as these were particularly vulnerable groups of people (20 units). A report was presented on 25 November by Alan Pryse, Healthcare Inspectorate Wales, which showed how the two waves of infection so far had affected residents. Particularly of note was concern about the lack of contact that patient aged 13-18 had been having with their families. It was agreed that work with the National Commissioning Group needed to be undertaken to improve support in these units. I produce the minutes of the NTG meeting on 25 November 2020, as exhibit **M2B.CNO.JW.01/113–INQ000299595.**

102. The NTG reported to the Maintaining Essential Services Group and all guidance was cleared by that cell before issue to executives in NHS Wales, social services, and other authorities, where appropriate. I do not recall any instance when the cell declined or changed the advice from the NTG before issue to the external services.

**Care homes**

103. I was not involved in the development of the policy or the provision of advice to Ministers around the discharge of asymptomatic hospital patients from hospital to care homes without a Covid-19 test in March and April 2020.

104. The issue of care homes was discussed regularly at EDT, with updates normally given by Albert Heaney, who had responsibility for policies related to social care including the care home sector. I produced earlier in my statement exhibit **M2B.CNO.JW.01/018–INQ000300088**, the notes of the EDT meeting on 8 April 2020. During this meeting, Albert Heaney, noted that Care Inspectorate Wales was requesting clarity from PHW on care homes and the approach to be taken on discharge from hospital to care homes. I am aware that Albert Heaney has been asked to provide

evidence to the Inquiry and these concerns may be covered in his statement in more detail and from a more informed position given his responsibility in this area. My recollections from that time include hearing concern being expressed from care home managers about the discharge of people from hospital to a care home setting due to worries that they would end up introducing the virus into the home and thus causing an outbreak. I believe part of the issue was on what to do with some patients who were still testing positive on the PCR test when clinically they had recovered from the infection and no longer contagious. PCR tests are very sensitive and will pick up fragments of virus and may indicate a positive result even when the person is not contagious anymore and this could potentially last for weeks. Lateral Flow antigen tests are less sensitive but will also indicate a positive result post the infectious stage of the disease. We were also sensitive to the possibility of individuals catching the virus if kept in an acute hospital setting where other infected patients are being treated. I believe Albert Heaney was seeking clarity from Public Health Wales in respect of this issue, but I do not recall the detail of the discussion or the outcome of Albert Heaney's request other than being informed later that month about the testing strategy for care homes.

105. I became aware of the testing strategy for care homes when the Ministerial advice MA/VG/1461/20, dated 30 April 2020, was submitted to the Minister for Health and Social Services. I am on the circulation list for ministerial advice to the MHSS. I produce a copy of this advice here, as exhibit **M2B.CNO.JW.01/114–INQ000299247**. This advice stated the current position on testing in Wales and went on to set out what further actions should be taken in the care home sector. The following is an excerpt from the briefing describing the testing in care homes position as it stood then: -

> *"Testing all individuals being discharged from hospital to live in care homes regardless of whether or not they were admitted to hospital with COVID-19.*
>
> *Extending COVID 19 testing to people who are being transferred between care homes and for new admissions from the community. We also intend to increase testing within care homes as more testing capacity becomes available.*
>
> *All individuals due to be discharged from hospital or transferred to a care home but have tested positive are provided with appropriate step-down care in local settings, such as in community hospitals which will be equipped for infection control and can also offer therapeutic support to aid individual recovery. They*

*will be tested again to ensure a negative result before returning to their care home.*

*Targeted testing and deployment of mobile testing units to test all residents, both symptomatic and asymptomatic, in care homes where an outbreak occurs, and potentially neighbouring care homes, with repeat testing the following week."*

106. In May 2020, the Welsh Government introduced large scale testing in care homes across Wales to prevent and manage outbreaks of Covid-19. The strategy was firstly about reducing harm, and then about easing control measures and using Wales' resources to best effect.

107. SAGE was asked to provide a scientific view on testing strategy to reduce transmission of Covid-19 in care homes. In light of the production of their report, further advice was submitted to the Minister of Health and Social Services on 14 May 2020. This led to an update on the strategy for testing in care homes in Wales. Again, I was copied into the circulation list when the briefing was submitted to the Minister. I produce here the ministerial advice (MA/VG/1619/20), as exhibit **M2B.CNO.JW.01/115–INQ000136783** and the SAGE report of 12 May 2020, as exhibit **M2B.CNO.JW.01/116-INQ000299676.** In June 2020, following the advice from SAGE, the Welsh Government introduced weekly testing of all staff in care homes across Wales, whether symptomatic or asymptomatic, to monitor the ongoing transmission of Covid-19. The weekly testing of staff in all care homes, including those yet to report an outbreak, was for a period of four weeks commencing on 15 June 2020, with care homes with positive results undertaking repeat testing as appropriate.

108. On 10 July 2020, further ministerial advice (MA/VG/2238/20) was provided on testing in care homes, which included the data from the four weeks of testing of care home staff. The decision was taken to continue weekly tests for a further four weeks then move to fortnightly testing. This was communicated by letter to the health boards and social care sector, signed by the CMO(W) and Deputy Director General. I was copied into the ministerial advice and the letter, for information. I produce here the ministerial advice, as exhibit **M2B.CNO.JW.01/117–INQ000299455**, and the letter, as exhibit **M2B.CNO.JW.01/118–INQ000299499.**

109. In my regular virtual meetings with the Nurse Directors, I asked about their work to support the care homes in their area. It was important that the health and social care systems worked together during the pandemic. In April, I asked for the local health boards' plans for working with their care homes, all showed actions being undertaken. I also emphasised to them the importance of testing patients prior to discharge to a care home. I produce here the minutes of the meeting held on 28 April 2020, as exhibit **M2B.CNO.JW.01/119–INQ000299245.**

110. Through my participation at meetings of the NTG and EDT, I brought attention to the work I was doing in respect of NHS hospital and hospice visiting with the civil servants from the social services directorate who sat in these meetings, to help them shape policy for the care home sector. Visiting to care homes was restricted at the same time as Welsh Government restricted hospital visiting. Instructions were issued to care homes on 23 March 2020. The purpose of restricting visiting was to protect residents, visitors and the staff who worked in that setting. From 1 June 2020, revised national Covid-19 regulations came into force in Wales, which enabled two households to meet outside. On 5 June 2020, the Welsh Government again wrote to care homes advising how they could facilitate outdoors visiting that complied with these new regulations. Further guidance on the use of facemasks was issued on 16 June 2020. The CMO(W) had advised that wearing facemasks was not necessary if people were meeting outside and were socially distancing by 2 metres. From 22 June 2020, it was permissible to travel outside your local area on compassionate grounds. This meant that relatives could travel to see their loved ones who were resident in a care home, if that care home was outside their local area. On 23 June 2020, Care Inspectorate Wales issued visiting guidance to care homes, promoting a risk based and compassionate approach to visiting, recognising the stress on residents restricting visiting had inflicted. I produce here, as exhibit **M2B.CNO.JW.01/120–INQ000300143**, the guidance issued by Care Inspectorate Wales.

111. Bank and agency staff have always been a feature of staffing in social care settings in Wales, in much the way it has been a feature in staffing the NHS. The Covid-19 infection prevention and control ("IPC") guidance referred to the need to cohort Covid-19 positive patients and staff to stop the spread of infection. As explained in paragraph 93.5, guidance was issued to health settings on 10 July 2020 about restricting movement of temporary staff and reminding them of the IPC guidance. The letter had been signed off by the DCMO(W), Helen Arthur, Director of Workforce and Organisational Development and me, and was shared with the NTG group members.

It had been planned that the letter of 10 July would also include guidance on the use of agency and temporary staff in care homes, because many of them work in more than one setting, however advice from Albert Heaney was that there were issues to work through with the sector before this could be done (I was not party to what these issues were). Therefore, the letter of 10 July only went out to the NHS. In August 2020, a letter of advice was issued by the Social Services Directorate to care homes advising on restricting staff movement. The opinion of infection prevention experts on the NTG was that minimising movement of workers between care homes was one way of reducing introduction of the virus into residences. IPC guidance in the form of a 16-point plan was issued at the end of October 2020, which referred to minimising movement of staff. At the NTG meeting on 5 November 2020, there was a discussion on the impact this advice was having. It was noted that because staffing levels were very stretched in the care sector, restricting the movement of staff was difficult and therefore compliance was patchy. I produce here, as exhibit **M2B.CNO.JW.01/121–INQ000300120**, the minutes of that meeting.

112. At the meeting of NTG on 5 November, the issue of data on Covid-19 infections in care homes was discussed. It was agreed that more was needed to be done to have a complete timely picture of infections to help understand the containment/spread and management of outbreaks. A working group was established, led by Dr Sara Hayes. However, post this meeting Dr Marian Lyons informed NTG members that a pilot had been trialled Aneurin Bevan University Health Board that would now be rolled out across Wales. This work led to improved surveillance in the care homes sector with a standardised reporting format.

113. The NTG acknowledged that it was critical that the knowledge and skills of care homes staff were improved in respect of infection prevention and control measures. Some people may have contracted Covid-19 but remain without symptoms, making transmission a very real possibility in closed settings such as a care home. On 3 November 2020, the Minister for Health and Social Services was asked to fund a six-month programme with national leadership and infection prevention and control training in the care home sector. The Minister agreed to allocate £108,100 for the programme, and the programme was subsequently established in early 2021. I produce here, as exhibit **M2B.CNO.JW.01/122–INQ000136825**, the briefing provided to the Minister for Health and Social Services, and as exhibit **M2B.CNO.JW.01/123–INQ000299690**, the Minister's approval.

114. An open letter, signed jointly by the NMC, Social Care Wales, the Deputy Director General and me, was issued on 7 May 2020 encouraging nurses who had left the professional register in the last 5 years to return so that they could support health and social care services in Wales. I produce a copy of this letter here, as exhibit **M2B.CNO.JW.01/124–INQ000299267**.

115. At the start of the pandemic in March 2020, the normal monthly census report (patient data gathered on a specific census day) setting out how many patients in NHS Wales hospitals had been delayed from being discharged to their preferred destination, was suspended. In its place, the Welsh Government introduced the Covid-19 discharge requirements which accelerated implementation of the discharge to recover then assess pathways (referred to as D2RA). Local health boards were asked to submit various returns during each week, that helped to manage the availability of acute beds and monitor where bottle necks were occurring that delayed discharge or transfers of care to places such as residential or care homes. The EDT paper and two annexes summarising delayed transfers of care (DTOC) were discussed at the EDT meeting on 23 September 2020. I produce here, as exhibit **M2B.CNO.JW.01/125–INQ000300121**, the EDT paper, and as exhibit **M2B.CNO.JW.01/126–INQ000300122**, the minutes of the meeting.

**Areas where I was not directly involved in providing professional or policy advice**

116. Aside from general discussion with other executive directors and the Director General, HSS at EDT Meetings regarding the proposed actions we should take, I was not involved in developing ministerial advice, gathering data, or conducting analysis concerning the imposition of, or easing of: -

116.1. national lockdowns

116.2. local and regional restrictions

116.3. working from home

116.4. social distancing

116.5. restrictions of mass gatherings

116.6. self-isolation

116.7. the closure or re-opening of schools

116.8. border controls

116.9. testing and tracing cases; or

116.10. shielding.

117. I did not contribute to the work to develop public health and Covid-19 legislation and regulations, including the Coronavirus Act 2020.

118. I did not engage with any voluntary sector organisations during the pandemic.

**Engagement with the Nurse Directors**

119. Throughout the pandemic, up until the time I retired, I kept close and regular contact with the Nurse Directors. Prior to the pandemic, I had monthly meetings with them as a group as part of a collective leadership approach to managing professional nursing and midwifery matters in Wales. These meetings enabled the sharing of information and an opportunity for discussion of emerging issues. It was therefore essential as the pandemic took hold and pressures on the health and care sector increased that this became an essential group with whom I should work. Meetings went to twice weekly from 19 March 2020, and returned to monthly on 26 June 2020. An example of an issue raised and dealt with through this route, in early April 2020, was in respect of concerns expressed by staff and the RCN on whether the Covid-19 virus could be transmitted on uniforms taken home to be washed. I arranged for Gail Lusardi, Nurse Consultant in Infection Prevention and Control to issue guidance on the wearing and laundry of uniforms. I emailed the Nurse Directors with that guidance and reminded them of their responsibilities regarding changing facilities on 15 April 2020 (see paragraph 81 of this statement, and the documents there exhibited).

120. Once the monthly routine meetings were reintroduced, I asked each of my nursing officers to produce a written update from their areas of responsibility to share with the Nurse Directors. This was updated for every meeting and provided links to core Welsh

Government advice and policy. I produce here an example of this Nursing Directorate 'Hot Topics' briefing, as exhibit **M2B.CNO.JW.01/127–INQ000300123.**

**Engagement with the UK Government and my UK counterparts**

121. I had limited direct engagement with the UK Government. This engagement was via the CNO(E) and her representatives, including officials from Health Education England when discussing issues affecting the training of nurses and midwives. I also sat on the UK Senior Clinicians meetings whose membership included the four CMOs, scientific advisers and public health leads from the four nations. I had no direct contact with UK Government civil servants.

122. The four UK CNOs had regular contact throughout the pandemic sometimes as a group, where we also included the CNO from the Republic of Ireland, sometimes individually if there was a request and collectively, and we all engaged with the work with the NMC regarding changes to the standards that govern nurses and midwives.

123. I produce here, as exhibit **M2B.CNO.JW.01/128–INQ000300129**, the terms of reference for the UK CNO meetings, as re-drafted on 6 October 2020. I also produce as exhibits **M2B.CNO.JW.01/129–INQ000300130**, **M2B.CNO.JW.01/130–INQ000300131**, **M2B.CNO.JW.01/131–INQ000300132**, **M2B.CNO.JW.01/132–INQ000300133**, **M2B.CNO.JW.01/133–INQ000300134**, **M2B.CNO.JW.01/134–INQ000300135**, **M2B.CNO.JW.01/135–INQ000300136**, **M2B.CNO.JW.01/136–INQ000300137**, **M2B.CNO.JW.01/137–INQ000300139**, **M2B.CNO.JW.01/138–INQ000299752**, **M2B.CNO.JW.01/139–INQ000300138**, **M2B.CNO.JW.01/140–INQ000300016**, and **M2B.CNO.JW.01/141–INQ000299797**, the minutes of the UK CNO meetings held on 17 January 2020, 12 March 2020, 21 May 2020, 5, and 19 October 2020, 10 and 24 November 2020, 22 December 2020, 8 and 22 January 2021, 5 and 19 February 2021, and 5 March 2021.

124. We occasionally contacted each other for specific things, for example the CNO(NI) contacted me on 13 October 2020 at the behest of her health minister seeking mutual aid in the form of qualified nurses to come and work in the NHS NI to help with their upsurge in Covid 19 cases. I discussed this with my health minister, who agreed with my advice not to send any staff because we too were seeing an upsurge in cases and were in the process of opening Field Hospitals that required staffing. This request for aid was also declined by Scotland and England. I produce here, as exhibits

**M2B.CNO.JW.01/142–INQ000299602** and **M2B.CNO.JW.01/143-INQ000299603**, the CNO(NI)'s request, and my response respectively.

125. I reached out to the CNO(E) to discuss guidance on nurse-to-patient ratios in intensive care. As a consequence of the discussion, I recommended to the health minister that we follow the same advice that NHS England was following, which had been produced by the UK Critical Care Nurses Forum. A statement was made in November 2020 (which I produce here as exhibit **M2B.CNO.JW.01/144–INQ000299697**) and updated in January 2021 (which I produce here as exhibit **M2B.CNO.JW.01/145–INQ000300140**).

126. I took part in a virtual discussion on requiring the public to wear face coverings when accessing healthcare settings with the UK CNOs, at the request CNO(E) because she had been asked to develop a policy position for NHS E. At that time, the CMO(W) had been urging caution about the use of public using face coverings generally because of the concern of inappropriate use by members of the public i.e., not adequately covering the nose and mouth, face touching leading to cross infection, making communication more difficult for patients who lip read, being seen as a barrier when dealing with children and young people. There were also concerns about stock availability. I fed back the discussion to the CMO(W) to feed into the advice he was preparing for Ministers. I understand that the outcome was that Wales was slower in adopting a policy mandating the public to wear face coverings in health care settings, although I was not directly involved in that decision.

127. Prior to the covid pandemic the UK CNOs and the CNO for the Republic of Ireland would meet on a quarterly basis (virtually and face-to-face), therefore the arrangements during the Covid 19 pandemic built on existing arrangements. The UK CNOs had good personal relationships and worked well together and provided peer support that was welcomed during the pandemic.

**Public Health Communications**

128. The use of public health communications and behavioural change strategies to promote personal safety of the population was discussed at EDT Meetings. While I contributed suggestions and comments to the policy leads during those meetings, I was not responsible for public health communications in Wales during the pandemic and decisions on this were taken by others with the necessary professional expertise.

129. I agreed to undertake a radio interview to help public understanding of the rules introduced for social distancing, including how family bubbles would work. I also produced a series of video messages that were shared on the Welsh Government's social media accounts.

**Lessons Learned**

130. I retired from my role as CNO(W) on 6 April 2021, so my comments relate only to the period that preceded my retirement.

131. I felt that the Welsh Government's response to the pandemic evolved quickly as we began to understand more about the disease: how it spread, what the symptoms were, why some people became extremely ill and died, who was most at risk, how to test and track the spread, what interventions worked and what didn't work, and the long-term effects for some individuals. I certainly felt as though we tried to gather information from as many sources as possible to help inform our policy advice.

132. It was clear from the beginning that the pandemic planning we had done in anticipation of an influenza outbreak (which we have experienced many times before) was not adequate for this novel virus. The population had no immunity to the disease and, consequently, all were susceptible to contracting it and potentially dying from it. While some elements of our preparation were still of value, other elements were less valuable. Wales has limited capacity for dealing with highly contagious diseases and limited intensive care provision, for example.

133. Supply chains for equipment like PPE were not robust and we relied on production in other countries. This was discussed at EDT Meetings on more than one occasion and I refer, by way of example, to the minutes of the EDT meeting held on 8 April 2020, exhibited as exhibit **M2B.CNO.JW.01/018–INQ000300088** at paragraph 27 of this statement. Accreditation and quality assurance of standards became an issue when new untried suppliers were accessed to source products. This suggests having a wider pool of providers who are accredited and an ability to quickly accredit and quality assure new suppliers of products in future.

134. There was much debate about how PPE should be used, by whom and in what circumstances. Guidance for health and social care staff went through many iterations, and there were frequent challenges for operational managers. Maintaining national

agreed guidance on the use and disposal of PPE, that is regularly updated, should be part of future pandemic planning.

135. Having a senior clinicians' group, like the one led by the CMO(E), that met regularly to share intelligence and work through a UK rather than individual country response, was very valuable and in the event of another pandemic I would suggest such a group is stood up immediately. This group must include the UK CNOs from the outset.

136. I certainly valued having direct contact with the operational leads in the Welsh NHS and care home sector. This ensured a two-way flow of information from the place where people were receiving care, to the political and system leaders.

137. On the ground intelligence, through sensitive surveillance was also something we had to develop and was a crucial way to monitor the spread of disease.

138. In terms of workforce, I believe establishing a temporary register that enabled health professionals who had recently left the register in the last three years, was a useful thing to do. The experience of offering paid placements for third year nursing students who were in the last six months of the course had mixed outcomes. Some students benefited from this experience, while others weren't able to take up the opportunity due to shielding, and some experienced delayed registration of up to seven weeks as a result. Offering students the option of doing paid bank nursing work as a health care support worker had less problems to overcome.

**Transcripts of evidence**

139. I gave evidence to two Senedd Committees: -

139.1. The Children, Young People and Education Committee of the Fifth Senedd on 5 May 2020 (and I produce here, as Exhibit **M2B.CNO.JW.01/146–INQ000300141**, a transcript of my evidence).

139.2. The Health, Social Care and Sport Committee of the Fifth Senedd on 27 January 2021 (and I produce here, as Exhibit **M2B.CNO.JW.01/147–INQ000300142**, a transcript of my evidence).

**Informal Communications and WhatsApp**

140. I did not use my personal mobile phone for communication about the Welsh Government's response to the Covid-19 pandemic, with one exception. I texted the then Minister for Health and Social Services, Vaughan Gething, on Saturday 11 April 2020 at 12.33pm, to inform him that sadly there had been deaths of two nurses in Prince Charles Hospital in Merthyr Tydfil and one death in Princess of Wales Hospital in Bridgend. He acknowledged receipt of this information.

141. I did not use WhatsApp for any work-related exchanges with my team, other civil servants, or ministers. I did contact my team members over WhatsApp as part of well-being checks as all were working remotely, but the Welsh Government's work and response to Covid-19 was not discussed in these conversations. I issued the following instruction to my team via WhatsApp on 31 January 2020:

"All please read the security SIRO. We must not have any work-related content on WhatsApp, e.g., it is OK to say there is an OAQ [Oral Assembly Question] to answer, but not OK to include what it asks. Jean."

**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 of its truth.

**Signed**: Personal Data

Professor Jean White CBE MStJ

**Dated**: 5 December 2023