Witness Name: Dame Ruth May

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COVID 19 INQUIRY

FIRST WITNESS STATEMENT OF DAME RUTH MAY

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I, Dame Ruth May, Chief Nursing Officer for England of Wellington House, 133-135 Waterloo Road, London, SE1 8UG, will say as follows:

INTRODUCTION

1. Responding to the pandemic was the greatest challenge that the NHS has ever faced and from a personal perspective, the most important and difficult challenge of my career.

2. Firstly, I want to thank every nurse, midwife, nursing associate, student, volunteer, and healthcare and maternity support worker for everything that they did at this extremely difficult time. I know what our NHS Staff went through and the sacrifices that they made to give the best possible care and support to our patients. The whole country was behind our NHS and thanks to your work, our professions will always be held in the highest regard.

3. I also want to thank all nursing and midwifery leaders for their leadership through the pandemic and for supporting their teams to deliver in these most challenging circumstances. My own team at NHS England worked at an incredible pace to support me across a wide range of issues for a long period and I also want to pay tribute to them for all of their hard work.

4. I know that the pandemic has had an enormous impact on our staff in terms of health and wellbeing. As well as the impact of working through the pandemic, all nurses, midwives, nursing associates, students, volunteers, and healthcare and maternity support workers working in all settings had to live through the same restrictions as the public. I remember being one of only seven people at my stepmother's funeral in April 2020; I remember saying goodbye to my dying mother-in-law through a window outside her care home in January 2021; like so many people, our staff will have stories like these of their own from this time.

5. As NHS leaders, it is key that we ensure that we use our learning from the pandemic so that we are better prepared and able to respond to future pandemics.

STATEMENT OVERVIEW

6. I make this statement in response to the UK Covid-19 Inquiry's Rule 9 request to me dated 8 November 2023 in relation to Module 3 of the Inquiry ("**the Rule 9 Request**"), which focuses on the impact of the Covid-19 pandemic on healthcare systems in the four nations of the UK between 1 March 2020 and 28 June 2022 ("**the Relevant Period**").

7. The Rule 9 Request covers a wide range of issues, including nursing and midwifery workforce, infection prevention and control ("**IPC**") and maternity services.

8. This statement is structured as follows:

   a. **Section 1** provides an overview of my professional background and the role of the Chief Nursing Officer ("**CNO**").

   b. **Section 2** provides an overview of the engagement structures in place during the pandemic (with reference to where they already existed pre-pandemic) to share information.

   c. **Section 3** outlines workforce arrangements, including capacity, re-deployment, testing for nursing and midwifery staff, wellbeing and inequalities.

   d. **Section 4** sets out my involvement in relation to IPC.

   e. **Section 5** details my involvement in decisions relating to maternity services.

   f. **Section 6** covers my involvement in Do Not Attempt Cardio-Pulmonary Resuscitation ("**DNACPR**") and the Clinical Frailty Scale.

   g. **Section 7** provides an overview of others matters within the scope of Module 3.

   h. **Section 8** considers lessons learned.

9. Throughout this statement I have set out my reflections and challenges that we faced.

10. This witness statement does not seek to duplicate the extensive factual material provided to the Inquiry in:

   a. NHS England's Module 2 Statement signed by NHS England's National Medical Director;

   b. NHS England's First Module 3 Statement signed by NHS England's Chief Executive Officer;

   c. NHS England's Second Module 3 Statement signed by NHS England's Chief Executive Officer;

   d. NHS England's Third Module 3 Statement signed by NHS England's National Medical Director; and

e. NHS England's Fourth Module 3 Statement signed by NHS England's National Medical Director.

11. I have drawn on key definitions from NHS England's Second Module 3 Statement, including:

a. definitions of the waves of the pandemic:

Wave and dominant variant	Dates (approx.)
Wave 1 – Wuhan variant.	February – May 2020
Wave 2 – emergence of Alpha variant.	September 2020 to January 2021
Wave 2 - reducing and the emergence of Delta variant.	February 2021 to September 2021
Wave 3 – emergence of Omicron variant.	September 2021 to end of the Relevant Period.

b. referring to the Department of Health and Social Care ("**DHSC**") and the Secretary of State for Health and Social Care ("**SSHSC**") in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require; and

c. collectively referring to NHS Trusts and NHS Foundation Trusts as "**Trusts**" unless otherwise stated.

SECTION 1: MY PROFESSIONAL BACKGROUND AND THE ROLE OF THE CNO

Role of the CNO during business as usual

12. I am the CNO for England and I have held this role since January 2019. I first started working within the NHS as a student nurse in 1985 and since then I have held various frontline and leadership roles as outlined in Annex 1.

13. The CNO role has existed in some form in England since 1941, pre-dating the creation of the NHS. The CNO post resided in DHSC until 2012 when, as part of the Health and Social Care Act 2012 reforms, it was moved to NHS England as further outlined in NHS England's First Module 3 Statement.

14. The role of the CNO is broad: although I am employed by NHS England I am also an adviser to DHSC, Government and the wider NHS on nursing and midwifery related issues.

15. The CNO role has the additional dimension of being the professional lead for the nursing and midwifery professions - there are currently around 386,000 nurses and midwives working for the NHS in England, who make up the largest group of the total NHS workforce. I am accountable for providing clinical and professional leadership for all nurses and midwives in England. Public health nurses were the responsibility of Public Health England's ("**PHE**") Chief Nurse until 16 November 2023, when I assumed professional leadership for this group of nurses. As a professional lead I seek to set an example and to uphold the vital work and the values of my profession.

16. It is important to note that providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed 'NHS workforce'. Accordingly, the workforce of Trusts and independent providers are not employed, or managed, by NHS England and I have no line management responsibilities in relation to nurses, midwives and/or nursing associates at these organisations (at any level).

17. I would distinguish my work into three categories for the purposes of this statement:

    a. what I was accountable for as an executive lead;

    b. where I was a collaborator (where my sign off was required at some point in an approvals process); and

    c. where I was a stakeholder or adviser (where my views were sought).

18. Within NHS England I am an executive director and I lead the Nursing Directorate. This means that I am responsible for the delivery of national programmes and policy areas that typically have a strong focus on nursing and midwifery. I also provide the nursing perspective and input into a wide range of clinical and operational issues that are the responsibility of other senior colleagues. My core accountabilities and deliverables are exhibited at **[RM/001] [INQ000421176]**.

19. The health and care system is large and complex, with a range of national bodies with specific roles and responsibilities. I have always found it enormously helpful to work across organisational boundaries to achieve shared outcomes and goals. I have always approached my role in a collaborative and inclusive manner, ensuring that the widest range of voices influence my work. This is known as my "**teamCNO**" approach.

20. During the Relevant Period, I was (and still am) supported by four deputy CNOs ("**DCNO**") within NHS England who provide senior leadership and support on specific

areas of my responsibilities. I was also supported by the Chief Midwifery Officer ("**CMidO**") and NHS England's Director for People and Communities. Details of the areas of responsibility for each member of my central team both at that time and at present are set out at Annex 2.

21. I also work closely with NHS England's seven regional teams through their regional Chief Nurses. Typically, one of the roles of regional Chief Nurses is to manage relationships with lead nurses in Integrated Care Systems, which include Trusts, who are responsible for the leadership of nurses and midwives within their own organisations.

22. The links between health and care in relation to nursing are numerous. I created a part time post of Strategic Advisor for Care Home Nursing within my team in February 2020 to strengthen these links and give care home nurses a greater role in teamCNO **[RM/002] [INQ000421233]**.

23. In December 2020, with my support, and as outlined in DHSC's *"Adult social care: our COVID-19 winter plan 2020 to 2021"* (published on 18 September 2020), DHSC established the post of the Chief Nurse for Adult Social Care to provide social care nursing leadership at DHSC. This post was originally created on an interim basis for nine months before becoming a substantive role for a period of three years from September 2021. I maintain a close working relationship with the Chief Nurse for Adult Social Care to support consistent leadership across all areas of nursing in England. The Chief Nurse for Adult Social Care reports to DHSC's Director General of Adult Social Care with a professional line to me as CNO. The Chief Nurse for Adult Social Care is part of teamCNO.

Role of the CNO during a pandemic

24. On assuming the role of CNO, I had a number of actions planned to support the delivery of my three strategic priorities:

    a. building the nursing and midwifery workforce;

    b. renewing the reputation of nursing and midwifery; and

    c. ensuring that nurses and midwives spoke with one collective voice.

    This included a series of events planned to mark the International Year of the Nurse and Midwife 2020.

25. The emergence of Covid-19 in early 2020 and the subsequent whole system response led to a rapid change of priorities, as I outlined in my speech to the CNO Summit in March 2020. My priorities for 2020 had become: our people; maternity; and Covid-19.

26. The Nursing Directorate played a full part in NHS England's response to the pandemic as detailed throughout this statement. The role of CNO does not have a public health emergency role when compared to, for example, the Accountable Emergency Officer role within NHS England which is typically undertaken by NHS England's Chief Operating Officer. However, as with all NHS England executive directors, and the organisation as a whole, my focus turned to managing the pandemic as new priorities rapidly emerged.

27. As the NHS England response developed and the cell structure was established, individuals from the Nursing Directorate were seconded into cells to provide clinical and operational expertise; further members of the Nursing Directorate joined frontline organisations to provide direct patient care. The Nursing Directorate was particularly represented in the Clinical, Workforce, IPC and End of Life Care cells, reporting to the respective cell's Senior Responsible Officer ("**SRO**"). I was the SRO for NHS England's IPC Cell, which dealt with NHS England's input into operational IPC issues for England.

28. To enable the pandemic response and cell structure to function, NHS England's executive directors identified work that could either be paused/slowed, maintained or accelerated/enhanced to respond to the pandemic in early March 2020.

29. As an executive director of NHS England, I attended a number of national meetings such as the Covid-19 National Incident Response Board ("**NIRB**") and Strategic Fusion. [1]

30. By way of brief background, NIRB originated from NHS England's Operating Framework for Managing the Response to Pandemic Influenza 2017 (referred to as the National Pandemic Influenza Incident Response Board) and anticipated the longevity of an influenza pandemic response. It became collectively known as the Covid-19 NIRB (referred to only as "NIRB" generally throughout the arrangements). NIRB's role was to support the discharge of NHS England's and NHS Improvement's respective duties and powers and their combined responsibilities by setting the

[1] Further details of NHS England's pandemic governance is set out in NHS England's Second Module 3 Statement.

strategic direction and overseeing NHS England's response. Example terms of reference detailing membership and duties are exhibited at: **[RM/112] [INQ000269949]** and **[RM113] [INQ000269979]**.

31. NIRB approved the evolving iterations of the Covid-19 operating model (iterations of the incident governance structure and cell structures were presented to NIRB), and was also the central link between the response and the NHS England Executive Group and NHS England Board.

32. Strategic Fusion was a daily problem-solving forum between Emergency Preparedness Resilience and Response ("**EPRR**") leadership and National Directors. The purpose of Strategic Fusion was stated in its terms of reference as to:

    cohere and co-ordinate cross-cell activity at a strategic level. It contributes to the understanding of cell and national operational functions, allowing management of strategic activity, escalation of issues where required (to the National Incident Response Board (NIRB)), and facilitation of information flows to contribute to situational awareness across the system.

    Example terms of reference detailing membership and duties are exhibited at: **[RM/114] [INQ000270028]** and **[RM/115] [INQ000269985]**.

33. During these meetings, I provided the nursing and midwifery perspective to a range of issues, informed by my colleagues (for example, community care, mental health, primary care and vaccines), as well as hearing their views and perspectives on the areas for which I was executive lead. When I was unable to attend, I was represented by my DCNOs, particularly the DCNO for Patient Safety and Innovation.

34. In addition to NHS England meetings, I was invited to attend meetings organised by DHSC such as the Senior Clinicians' Group (also known as the Senior Clinical Leaders Group) convened by the Chief Medical Officer ("**CMO**"). These broader set of meetings helped to: ensure that I was up to date on the wider issues outside of my direct responsibility so that my decisions took into account the latest developments; and provide the professional nursing and midwifery perspective (as appropriate).

35. As set out in NHS England's Second Module 3 Statement, NHS England regularly issued operational guidance during the pandemic. I was involved in the production of guidance where the subject matter covered areas where I had a national leadership role for example nursing workforce, IPC and maternity. My team and I also

contributed to guidance in areas led by other NHS England executives. Further information regarding my role in operational guidance is set out within this statement.

SECTION 2: ENGAGEMENT STRUCTURES

36. My teamCNO ethos was further strengthened during the pandemic as new relationships and structures were built or enhanced.

37. As a visible professional lead for the nursing and midwifery professions, I engaged in a wide range of activities, including: appearing on the No.10 podium for the daily coronavirus briefings; media appearances and fronting filming to support the NHS app and thank you messages to NHS staff; working in frontline NHS organisations and care settings; and many visits to NHS organisations, as detailed further below.

UK CNO engagement

38. CNOs in the devolved administrations have a similar professional leadership role. My relationship with fellow UK CNOs has always been important to me. Prior to the pandemic, I formally met with my UK and Republic of Ireland CNO colleagues on a quarterly basis to discuss issues relating to our professions, covering matters within our own areas of responsibility as well as international and UK and ROI-wide nursing matters. Each meeting was chaired by the host CNO in rotation.

39. As the pandemic developed, I met with my UK CNO colleagues to discuss urgent issues more frequently. We were involved in 12 meetings together in March 2020, 7 in April 2020 and 7 in May 2020. These meetings covered a wide range of pressing issues, particularly: the work being done with the Nursing and Midwifery Council ("**NMC**") (the regulator for nursing and midwifery professions across the UK) to expand the nursing and midwifery workforce through the establishment of temporary registers for returning staff; nursing students and internationally educated nurses; IPC measures and guidance; and Personal Protective Equipment ("**PPE**") supply **[RM/116] [INQ000477779] [RM/117] [INQ000477780] [RM/118] [INQ000477781]**.

40. Some of these meetings also involved the NMC, for example: during March and April 2020 when discussions on the temporary registration of a wide range of workforce groups were ongoing. These meetings provided a forum to discuss UK wide issues impacting on regulation with the professional regulator. This included areas such as the NMC establishment of the temporary register, potential deployment of students and approaches to Fitness to Practice during the pandemic. These meetings allowed

for the four nations to work together within the regulatory space at a UK level and to discuss where deployment between the nations would differ.

41. These meetings with the UK CNOs continued throughout the pandemic and to this day on a fortnightly basis, again with a rotating chair arrangement. Terms of Reference for the group were agreed in October 2020 (the latest update of these was in January 2024) and I continue to find these meetings extremely helpful and productive forums for discussion of UK-wide nursing and midwifery issues **[RM/003] [INQ000300129]**.

Government Engagement

42. In addition to my strong working relationships with my fellow CNOs, I have always enjoyed a strong and constructive working relationship with the Chief Medical Officer for England ("**CMO**"). Our roles are similar in terms of professional leadership, but different in terms of responsibilities - the CMO role is focused on providing advice to the Government on medical and public health matters.[2]

43. The CMO convened the Senior Clinicians' Group, which met on a regular basis throughout the pandemic to provide advice on a range of pandemic issues. I was not part of this group from its outset, but I asked the CMO to be involved given the importance of nursing and midwifery in the pandemic response and he was more than happy for this to happen – I started attending from 16 March 2020. Subsequently, I asked for the other UK CNOs to join. In addition to my attendance, and that of other senior NHS England clinicians such as the National Medical Director, NHS England's National Clinical Director ("**NCD**") for IPC and Hospital Onset COVID ("**HOCI**") Working Group (see Section 4) co-chair also attended these meetings, which linked up and enabled discussion of nosocomial (hospital acquired) infection issues by a wide range of senior clinicians.

44. As the Government's professional adviser on nursing and midwifery issues, I attended regular meetings with DHSC Ministers throughout the pandemic. As noted in NHS England's Module 2 Statement, I was invited to join the regular Test and Trace meetings by DHSC in June 2020, before responsibility for attending these was handed over to NHS England's National Director for Emergency Planning and

[2] NHS England has a National Medical Director who is employed by NHS England as set out in more detail in NHS England's First Module 3 Statement; I work together closely with the National Medical Director as colleagues and members of the NHS England Board.

Incident Response. I also attended the DHSC convened Joint Biosecurity Centre 'silver' and 'gold' meetings alongside other senior NHS England colleagues.

45. I met with the SSHSC and DHSC Ministers throughout the Relevant Period on issues relating to my operational responsibilities, as had been the case before the pandemic. This included meeting with the SSHSC on: workforce issues in June and November 2020 and January 2021; IPC three times in June 2020; and maternity in April 2020 and March 2021. I also attended a range of wider meetings alongside the SSHSC, such as the Joint Biosecurity Centre (gold) meetings.

46. I also had frequent meetings with DHSC Ministers on related matters, including:

    a. a weekly workforce meeting with the Minister for Care and subsequently the Minister of State for Health;

    b. the 50,000 Nurses Programme board chaired by the Minister of State for Health; and

    c. regular meetings with the Parliamentary Under Secretary of State on maternity services.

47. These meetings were complemented by regular ongoing meetings and dialogue with DHSC officials on operational NHS issues to support ministerial decision making in these areas.

48. My role also involved working alongside PHE, which was principally focused on the production of the UK IPC Guidance: a single coherent source of IPC advice published by PHE which reflected input from IPC experts across the UK. Further details regarding UK IPC Guidance is set out at Section 4 below and in NHS England's Third Module 3 Statement. I also worked with the Chief Nurse for Public Health, who was based in PHE, on a range of issues including the role of public health nurses during the pandemic, as outlined below.

49. My working relationship with No.10 and the Cabinet Office was built around formal meetings (such as COVID-O committee attendances) and ongoing dialogue with officials, such as on care home IPC training and nosocomial infections. This engagement was on a far less frequent basis than with DHSC; NHS England's usual route of engagement with Government is via DHSC, given DHSC's role as NHS England's sponsor department.

50. I was invited to appear as part of the Government's daily coronavirus briefings to the nation in 2020:

   a. On 3 April, I thanked all of those involved in the work done to establish the London Nightingale facility, which had been formally opened that day. I also commemorated the sad deaths of the first nursing colleagues, highlighting their service and the extraordinarily difficult situation faced by all of our frontline NHS staff, emphasising the need for the public to stay at home as per the guidance at the time.

   b. On 10 April, I further emphasised the stay at home messaging in the context of the long Easter weekend and thanked our NHS and social care staff for the work that they were doing to save patients' lives, along with the contribution of all other key workers which supported the NHS to do this. I also noted the importance of staff being able to use the appropriate PPE and how vital it was for people to continue to use the NHS if they needed it, particularly in the case of pregnant women who may be concerned by any changes to their condition or that of their baby.

Engagement with the frontline

51. It is important that senior nursing and midwifery leaders take into account the views of frontline nurses and midwives. Coming into the pandemic, one of my main objectives had been to build collective leadership and a shared vision for nursing with frontline colleagues. This approach underpinned my extensive service engagement throughout the pandemic.

Groups

52. I already had in place a number of structures and meetings to discuss nursing and midwifery issues face to face with colleagues in NHS organisations. These were enhanced through the pandemic and new structures were also created to ensure that an even wider range of voices were heard.

53. For example, prior to the pandemic, I had established weekly CNO calls on Fridays involving my senior leadership team, senior nurses from Health Education England ("**HEE**"), PHE and regional Chief Nurses. These calls were weekly before early April 2020 when they became bi-weekly, on every Tuesday and Friday. This forum was useful not only for communicating messages across the system but even more so in

hearing from the regions what messages and issues were coming up from the frontline as the pandemic developed.

54. During the early stages of the pandemic I established an informal strategic advisory group consisting of some of the most experienced and senior Chief Nurses from NHS organisations across England. This group first met on the afternoon of Sunday 15 March 2020. I used these weekly meetings to seek views and feedback on a range of operational issues including workforce pressures, IPC and PPE availability.

55. On 6 May 2020, and following approval of its terms of reference at NIRB on 29 April, these meetings became a formal bi-weekly group: the NHS Directors of Nursing Strategic Advisory Group ("**CNO SAG**"), **[RM/119] [INQ000087544]**. On 6 May, at the first formal meeting, the terms of reference set out that the aims and objectives of the CNO SAG were to ensure that the CNO had access to advice from a group of senior nursing and midwifery professionals to help inform decisions during the pandemic (including on workforce and clinical issues) and to provide a consultation group where new nursing or midwifery operational policy was proposed and discussed as appropriate.

56. The CNO SAG meant that I was connected to, and received valuable input from, senior nurses in the NHS to help me ensure my work and any subsequent decisions reflected the experience of frontline staff. For example:

    a. the plans for returning staff and student deployment were discussed in March 2020;

    b. universal mask wearing in healthcare settings in June 2020 **[RM/120] [INQ000477788]**; and

    c. the 10 key actions required to manage nosocomial (hospital acquired) Covid-19 infections in November 2020 **[RM/121] [INQ000477793] [RM/122] [INQ000477794]**.

57. As well as this group of senior nursing leaders, I also engaged with Directors of Nursing ("**DoNs**") of Clinical Commissioning Groups ("**CCG**") and Trusts' DoNs throughout the pandemic. I held 57 webinars with DoNs between March 2020 and June 2022 to discuss major issues and provide updates on new developments. These webinars were interactive, providing a forum at which comments could be made and questions and new topics raised. Many of these webinars were joint

DoN/Medical Director sessions, which I co-chaired with NHS England's National Medical Director.

58. In addition to my own involvement and that of the NHS England's National Medical Director, other senior national leaders joined us for webinars which focused on specific issues. For example, PHE's Deputy Director of the National Infection Service joined us on 8 April 2020 for a webinar on UK IPC Guidance, where issues around implementation of IPC guidance and supplies of PPE were shared and discussed. The feedback from senior nurses and medics via these webinars was important in ensuring that national guidance took into account operational issues and supported implementation.

59. An existing group which provided me with immense support and valuable input during the pandemic was the CNO and CMidO Black and Minority Ethnic Strategic Advisory Group ("**CNO BME SAG**"). This group had existed for a number of years, giving a voice to Black and ethnic minority NHS nurses and midwives.

60. Thanks to its many links to the frontline, the CNO BME SAG was involved in raising the issue of the disproportionate impact of Covid-19 on Black, Asian and minority ethnic staff and patients in April 2020. This feedback played an important role in prompting the work of NHS England and PHE in exploring this issue. Further to this, on 10 June 2020, the CNO BME SAG shared with me a summary report of the issues discussed at their nine teleconferences, covering all seven NHS regions, which took place between 23 April and 15 May 2020, involving 1,600 attendees. This report provided the first feedback on issues for specific ethnic groups and individuals with the fit testing of "filtering face piece 3" ("**FFP3**") masks, which are used when treating patients with Covid-19 in settings such as intensive care or other areas where aerosol generating procedures would be undertaken. These masks have a filtering efficiency of 98% and are also called FFP3 respirator masks. This feedback ultimately prompted the fit testing quality improvement project led by my then Deputy CNO for Patient Safety and Innovation, which is detailed within the NHS England's Third Module 3 Statement and below at Paragraphs 262 to 263.

61. The CNO BME SAG has continued to provide me with valuable feedback and act as a sounding board for national work. It was also particularly helpful in communicating national messages (via its regional structure) to its network throughout the pandemic, offering engagement events and webinars, as well as support spaces for Black, Asian and minority ethnic colleagues.

62. In addition to the CNO BME SAG, a group specifically representing Black, Asian and minority ethnic men in nursing, the Jabali Men's Network, also provided me with important links and information relating to the impact of the pandemic on our Black, Asian and minority ethnic staff and communities throughout the Relevant Period.

63. The network was developed for Black, Asian and minority ethnic male colleagues in their roles as senior leaders in the NHS to support and influence policy development in a way which promotes equality, equity and diversity. The Network provided valuable contributions on a range of issues in the Relevant Period, including the impact of Covid-19 on Black, Asian and minority ethnic colleagues, as well as providing a space for mutual support and development.

64. Another important element of my teamCNO approach is the CNO National Shared Professional Decision Making Council ("**the National Council**"). This group consists of a wide range of frontline nurses (with a separate group being established for midwives) to enable a non-hierarchical approach to collective leadership and discussion of key issues affecting all nurses. This group was first convened on 25 May 2020 and in this period it helped support the pandemic response.

65. The National Council met regularly throughout the pandemic, enabling discussions with frontline staff on issues such as enabling visiting (June 2020), staff health and wellbeing (July 2020), BME staff risk assessments (July 2020), IPC (August 2020), second wave preparations (October 2020) and delivering the vaccine programme (January 2021). Subjects for discussion were proposed by council members based on the issues that were being raised within their organisations.

66. This forum has proven to be an extremely helpful window directly into frontline experience. As well as the National Council, other subject specific councils were established such as for healthcare support workers (September 2020), IPC (October 2020); International Nurse Recruitment (November 2020); and Mental Health Nursing (March 2021). These were in addition to a midwifery focused group to support the CMidO, which was established in August 2020. As of February 2023, over 175 national meetings had taken place, with almost 300 active members of these groups **[RM/123] [INQ000477805]**.

Direct service engagement

67. To support our workforce and gain a first hand understanding of the circumstances in which nurses and midwives were working in the pandemic, there were 29 occasions where I worked on the frontline in the NHS organisations:

a. Six times in the critical care unit at Colchester Hospital (April 2020 – January 2021).

b. Four times on acute wards at Colchester Hospital (April 2021 – January 2022).

c. Once in the maternity unit at Colchester Hospital (May 2020).

d. Once on the fracture ward at Ipswich Hospital (May 2020).

e. Twice in the London Nightingale facility (April 2020).

f. Fifteen times administering Covid-19 vaccines at Colchester and Gainsborough (December 2020 – December 2021).

68. In addition to these, I also undertook five training sessions, a volunteer check in call (June 2020) and worked in a care home (May 2020). Most of these were at my local hospital in Colchester and I want to thank the Chief Executive for enabling me to do these and my nursing colleagues there for welcoming me.

69. These experiences gave me an important perspective on the issues and challenges being faced by the professions during the pandemic, including: working in unfamiliar settings, with limited visiting for the public; wearing respiratory protective equipment in intensive care units for long periods; and treating patients with Covid-19 who were seriously unwell, many of whom sadly died. These experiences had a long lasting personal impact on me. I knew that the impact on colleagues who had to do this day after day, for many months, must have been extensive and it greatly influenced my work to best support and protect nurses and midwives.

70. In addition to this frontline work, I undertook a programme of visits to a full range of NHS services throughout the Relevant Period, as and when restrictions permitted. My visits included Covid-19 wards, NHS Nightingale facilities (including London and Harrogate), secure mental health and justice NHS settings, maternity services, community NHS services, vaccination centres, children's services and a Long COVID clinic.

71. These visits were invaluable in showing the impact of measures introduced during the pandemic on NHS services and staff as well as the dedication and commitment of our staff in delivering for patients.

Care Homes

72. As outlined above, I attended some meetings with Government ministers and officials relating to care homes, specifically in relation to IPC. Many of these were focused on the IPC training offer made to care homes under mutual aid arrangements in 2020.

73. My team, particularly my DCNO for Professional and System Leadership, together with colleagues working in NHS England's Primary Care Directorate, including NHS England's Director of Community Health and regional Chief Nurses, drove this work forward as we felt that it was vital to support care homes to protect their residents.

74. Following consideration at NIRB on 29 April 2020, NHS England's Director of Community Health and I wrote to CCG DoNs on 1 May 2020 asking them to make a formal offer to provide IPC training to care homes. Over the course of May 2020, this offer was implemented successfully by a range of colleagues across England, with regular reporting ensuring that progress was monitored centrally. By the middle of July, a formal training offer had been made to almost every care home in England, with training taking place in 11,509 care homes.

Stakeholder engagement

75. Over the course of the pandemic, I engaged with a wide range of external organisations, many of whom I already had productive working relationships with. Most prominent among these were the representative bodies for the nursing and midwifery workforces, the Royal College of Nursing ("**RCN**") and Royal College of Midwives ("**RCM**") and the regulatory body for nursing and midwifery, the NMC.

76. I also had regular engagement with trade unions, for example Unison, as well as the medical Royal Colleges, particularly the Royal College of Obstetricians and Gynaecologists ("**RCOG**"). I did not have engagement with the Health and Care Professions Council as their primary relationship would be with the Chief Allied Health Professions Officer, who provides professional leadership for allied health professionals.[3]

77. Working in partnership with external organisations is important to me. The frequency of my engagement with these organisations can be found at Annex 3. As this

[3] There are 14 allied health professionals: Art therapists, Dietitians, Dramatherapists, Music therapists, Occupational therapists, Operating department practitioners, Orthoptists, Osteopaths, Paramedics, Physiotherapists, Podiatrists, Prosthetists and orthotists, Radiographers and Speech and language therapists.

highlights, engagement was high throughout the Relevant Period, particularly when the situation was rapidly changing in the early months of the pandemic.

78. In terms of my engagement with the RCN during the pandemic, this was largely focused on two of the main areas covered in this statement: nursing workforce and IPC. I generally spoke to the General Secretary and Chief Executive of the RCN. My DCNOs engaged with other senior leaders within the RCN on specific areas relevant to their portfolios.

79. I worked hard to involve the RCN in discussions on these important issues and take their views on board. Although we didn't agree on every issue, our working relationship remained strong throughout the pandemic, and I want to thank their Chief Executives who I worked closely with during the Relevant Period for their engagement.

80. Engagement with the NMC was also extensive throughout the pandemic. Our work together in supporting the NMC's temporary registers was vital and I was grateful for their support for our professions to respond to the pandemic, for example, as outlined in our joint letter of 12 March 2020. **[RM/004] [INQ000283205]**

81. I met regularly with the RCM and RCOG to discuss issues relating to maternity services. These meetings were not just specific to pandemic-related maternity issues but also covered wider maternity work, particularly in the wake of the publication of the first report of the Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust on 10 December 2020.

82. As well as engaging with key stakeholders on a one-to-one basis, I periodically joined NHS England's National Medical Director's fortnightly calls with the heads of the Royal Colleges. These calls included the RCN, RCM and RCOG and were a valuable forum for engaging with clinical stakeholders on a multi-professional basis, particularly on issues that affected the entire workforce such as IPC (which was also discussed with the Deputy Director of PHE's National Infection Service on 18 April, 11 May and 19 May 2020).

83. My maternity team, led by the CMidO and NCD for Maternity, also engaged extensively with RCM and RCOG, in particular when working in partnership to jointly produce guidance to support partners visiting hospitals and providing support to pregnant women throughout their maternity journey. Further details on this can be found in Section 5 below.

84. My engagement with trade unions such as Unison and Unite were mainly focused on issues relating to the steps taken to increase workforce capacity during this period, including student deployment and workforce terms and conditions, particularly in March/April 2020 and in December 2020 when these issues were extremely urgent. I also engaged with them on issues such as IPC and PPE for NHS staff.

85. I have always enjoyed a strong working relationship with national nursing and midwifery charities. I worked closely with the Florence Nightingale Foundation, who promote nursing leadership and during the Relevant Period, I supported their Nightingale Frontline service, which offered leadership training to nurses and midwives.

86. I also work closely with the Queen's Nursing Institute ("**QNI**"), the community nursing charity, the Cavell Trust, the Foundation of Nursing Studies and the RCN Institute and I remain grateful for the leadership that these charities and others provided during the pandemic and thereafter.

SECTION 3: WORKFORCE

87. The section covers my role in actions relating to our workforce, broken down according to the main workforce groups that supported the increase in capacity during the pandemic. This section also covers my role in the health and wellbeing of nurses and midwives, the redeployment of nurses from their normal clinical roles and staff testing.

Pre-pandemic position and early plans

88. As noted above, upon becoming CNO, building workforce capacity was one of my main priorities. In December 2018, there were 39,686 nursing and midwifery vacancies in the NHS in England. Over the course of 2019, teamCNO was able to work with the Government to: deliver a new minimum £5,000 maintenance grant payment to student nurses, midwives and allied health professionals; secure £150 million funding for continuous professional development of these professions; and ensure an additional 5,000 clinical placements for student nurses.

89. Building on the above actions over the previous 12 months, DHSC launched the 50,000 Nurses Programme in December 2019, which aimed to deliver an additional 50,000 nurses for the NHS in England by 2024/25. As part of this programme:

    a. I was responsible for International Nurse Recruitment;

b. HEE in the form of their Chief Nurse led on domestic nursing supply (students, nursing associate conversion and returners to practice); and

c. NHS England's Chief People Officer ("**CPO**") led on nursing retention programmes.

90. In the light of projected impact of Covid-19, taking rapid action to build nursing capacity in the NHS was my immediate priority. The need for greater workforce capacity in the event of a pandemic was demonstrated on 12 February 2020, when a request to establish a workforce workstream to take actions to mitigate a projected 20-30% absence rate was made by NHS England's Strategic Incident Director for Covid-19 **[RM/005] [INQ000421154]**. The option of using the student workforce and recently retired staff was already being considered from this point and my team were involved in these discussions **[RM/006] [INQ000421157]**.

91. My DCNO for Patient Safety and Innovation attended 'Two Steps Ahead' meetings convened by NHS England's Strategic Incident Director for Covid-19 on 14 and 21 February 2020 where nursing capacity was discussed in more detail in conjunction with the developing modelling of the potential impact of the pandemic on NHS services.

92. Planning for the impact of a pandemic on the workforce was also being considered by the professional regulators, who issued a statement on 3 March 2020 outlining that their regulatory standards were designed to take into account a wide range of situations and contexts **[RM/007] [INQ000421210]**.

93. NHS England's Workforce Cell were responsible for the overall approach to workforce and for the operational elements of deployment. To support these approaches, my role was to work with the system to develop effective routes to maximise the potential capacity of registrants to be deployed. I attended the NIRB meeting on 5 March when the workforce implications, including plans for the Government to introduce emergency legislation to allow for the return of staff to the workforce, was discussed. On 6 March, I discussed what this could mean for students with the Chief Nurse of HEE.

94. My DCNO for Policy and System Transformation joined discussions with the NMC on 6 March to consider the practical implications for returning staff, where the NMC outlined the legal changes required to contact and temporarily register those who were eligible and interested. From this meeting, weekly calls with UK CNOs and the

NMC were established to support this work, the first of which took place on 12 March 2020.

95. At this time, I was aware that DHSC had started discussions with professional regulators about the legislative changes required to temporarily increase the workforce. The NMC wrote to DHSC on 6 March 2020 with potential groups for inclusion on a temporary register, including those who had recently left the register and nursing and midwifery students in the final six months of their education, should the SSHSC request that this process be established.

96. Over this period, my team fed into NHS England's work to support DHSC's emergency Covid-19 legislative plans. My team also linked this work with colleagues in NHS England's People Directorate, who were leading on coordinating the overall approach for the NHS workforce. Discussions at the NIRB meeting on 10 March outlined the groups identified across all clinical professions to potentially support the NHS. On 13 March at NIRB, further details were provided including plans for a central team within the People Directorate to support deployment of returning staff.

97. UK-wide consensus for the proposals was important as the NMC is the regulator for the whole UK. Following discussions between the UK CNOs, NMC, Council of Deans of Health and stakeholders (RCN, Unison and RCM), a joint letter was issued on 12 March outlining support for staff in the pandemic and the plans for students and returning staff **[RM/004] [INQ000283205]**.

98. As well as students and returning staff, other workforce groups such as registered nurses in non-clinical roles, internationally educated nurses and healthcare support workers ("**HCSW**") were included in the plans to increase capacity to respond to the pandemic. My letters to DoNs on 19 March ("**the Four Point Plan letter**") and 6 April 2020 ("**the Seven Point Plan letter**") communicated the plans and actions for these groups of nurses and midwives **[RM/008] [INQ000421158] [RM/009] [INQ000421162]**.

Return of nursing and midwifery staff no longer on the NMC register

99. Colleagues who had recently left the NMC register were identified as a potential resource to support the NHS at an early stage. These individuals were prioritised as many of them would still be familiar with the skills required to work in frontline roles.

100. The letter from the NMC to DHSC dated 6 March 2020 outlined that the number of individuals under the age of 65 whose registration had lapsed in the previous three

years was around 60,000 in the UK (51,000 of these in England). However, given the age profile of this cohort many of these were expected to be working elsewhere in the labour market outside of the nursing profession rather than to have retired from work. This was expected to have a significant impact on the numbers who would be in a position to return to work in the NHS.

101. Following discussions and agreement with the UK CNOs and DHSC, the NMC contacted this cohort of nurses who had recently left the profession on 20 March 2020, in anticipation of the legislation being passed to allow them to be temporarily registered. Once this legislation came into effect, the register was opened on 27 March. Further discussions led to the register to be widened on 2 April 2020 to also include nurses and midwives who had left the register between four and five years previously **[RM/010] [INQ000421217]**.

102. As outlined in NHS England's Second Module 3 Statement, the overall work to support returning staff was coordinated by the 'Bring Back Staff' ("**BBS**") programme, under the leadership of the People Directorate. Our work, along with similar work led by other professional leads, fed into this overall programme.

103. To support the process of checking and deploying returning nurses led by BBS, a returners survey was established (to be completed alongside the NMC application form), to capture clinical background, skills and any preferred organisation. This was established to ensure that the complexity of the nursing and midwifery professions was reflected and understood at a national level within the BBS programme and to enable information to be shared with regional HR Directors to speed up appropriate deployment.

104. BBS data showed that the conversion rate for returning healthcare staff from expressions of interest to employment was low. As noted in NHS England's Second Module 3 Statement, there were various challenges despite a willingness to help. In relation to this low conversion rate, I believe that the key issues were:

    a. BBS regional capacity being initially insufficient to process the applications to return to practice that started to come through from 20 March;

    b. delays due to regional teams not being able to complete the volume of pre-employment checks required for the returning staff. Daily data that I was receiving from the NMC at this time showed that there was a significant response from nurses but pre-employment checks were becoming a bottleneck **[RM/011] [INQ000421170] [RM/012] [INQ000421190]**;

c. a disconnect between what Trusts needed and what returners were either available to do (in terms of hours, working in patient facing roles) and were able to do (not having the specific critical care skills); and

d. there being no established method of capturing whether the returners had been deployed at Trusts.

105. My team and I raised concerns with the People Directorate and BBS team in relation to these issues at the time. As noted in Paragraph 103 above, my team had established a returners survey to capture specialist information from returning nurses and midwives to mitigate the issue of a skills mismatch, however, the key issue was the speed at which applications were being processed. As a result, Trusts responded to Wave 1 through a combination of internal redeployment, which they were able to do as a result of the reductions in non-urgent activity as advised in the letter of 17 March "*Next steps on NHS response to COVID-19*" (the "**Phase 1 Letter**") **[RM/124] [INQ000087317]** as further discussed in Section 7, alongside the increases in the number of internationally educated nurses joining the NHS and the deployment of nursing and midwifery students into frontline organisations, as outlined below.

106. I greatly appreciated the commitment from returning staff and their desire to help the NHS at this very difficult time. I jointly wrote with fellow professional leads to all returners on the 2 July 2020 thanking them for their efforts **[RM/013] [INQ000421178]**.

107. My letter dated 10 September 2020 outlined plans for the 6,000 temporarily registered nurses and midwives who had completed pre-employment checks to support the continuing recovery of non-Covid-19 services as well as help to manage any further Covid-19 waves **[RM/014] [INQ000421186]**.

108. This letter outlined the regionally-led processes to support deployment into priority areas, an approach informed by learning from the processes in Wave 1, where there were examples of how local relationships (e.g. nurses contacting their former employers offering to return) enabled rapid deployment. A local approach was also recommended by the Nursing 7 Point Plan Review, detailed in Section 8 below. My letter also outlined how we would work in partnership with HEE to support those who wished to return to the NMC register on a permanent basis.

109. The NMC's temporary register remained open for nurses to apply to return to clinical practice throughout the autumn of 2020. It was further extended on 16 December 2020 to nursing and midwifery professionals whose registration lapsed between 1

March and 30 November 2020, with the aim of supporting the vaccine rollout **[RM/015] [INQ000421212]**.

110. As outlined in NHS England's Second Module 3 Statement, returning staff from December 2020 to June 2021 (when the BBS programme closed) were largely refocused to deliver national programmes, such as the Covid-19 vaccine programme, with Trusts using internal redeployment to support the pandemic response. Another notable area of contribution from the BBS programme returners at this time was their help in reducing the Continuing Healthcare[4] backlog which had developed post Wave 1. The Continuing Healthcare backlog arose when NHS Continuing Healthcare assessments were paused as a result of the Coronavirus Act 2020[5]. Working alongside colleagues in the Primary and Community Care Directorate, my DCNO for Professional and System Leadership coordinated the work to reduce these backlogs and returning staff played a significant role in enabling this to happen.

111. The possibility of closing the NMC's temporary register was first raised for discussion by the NMC Chief Executive at the UK CNOs and NMC meeting on 19 January 2022.

112. On 16 February 2022, the NMC Chief Executive shared their plans to announce the closing of the register to new applicants from the end of March 2022. The NMC also requested that the Government provide three to six months' notice ahead of the temporary registration ending to allow eligible people time to move to the permanent register if they wanted.

113. The decision to close it was announced on 21 February 2022 with further details of the decision being shared in a letter to me and the CMidO from the Interim Deputy Director, Professional Regulation at the NMC on 4 March 2022 **[RM/016] [INQ000421202]**.

114. I became aware of the SSHSC's subsequent decision to retain the NMC's temporary Covid-19 register on 21 September 2022 **[RM/017] [INQ000421204] [RM/018] [INQ000421205] [RM/019] [INQ000421206]**.

Student nurses and midwives

115. Pre-registration nursing and midwifery education typically consists of a three-year degree programme designed to equip nurses and midwives with the necessary

[4] Continuing Healthcare (referred to as "CHC") is where some NHS patients qualify for social care which is funded by the NHS.

[5] Further information about legislative measures are set out in NHS England's Second Module 3 Statement.

knowledge, skills and experience to provide safe and effective care to patients in various healthcare settings. The standards for education are set by the NMC who also quality assure programmes.

116. The NMC standards require 2,300 hours of academic study together with 2,300 hours in supervised, practice-based learning, in a “supernumerary” capacity. Supernumerary practice means learners are not counted in staffing numbers, protecting learning time supported by experienced supervisors and assessors.

117. The support that final year student nurses could give the NHS in the event of a pandemic was considered from an early point. The number of nursing students in the final six months of their education (identified in March 2020) was around 18,700. This proposal required careful consideration due to factors such as the potential impact on education as well as the terms by which any deployment could take place.

118. A series of discussions took place with senior leaders in NHS England and a range of stakeholders as this proposal was being considered. On 9 March 2020, I discussed the proposal with NHS England's Chief Executive and my fellow national executives, outlining the number of potential students who could be deployed. On the same day, the Chief Nurse of HEE and I met with the Chair and Chief Executive Officer of the Council of Deans of Health, which represent UK universities engaged in education and/or research for nursing, midwifery and the allied health professions, to discuss this proposal. Following this, I also discussed the potential support which nursing and midwifery students could provide with my senior leadership team and the RCN and NMC. As these discussions progressed, workforce planning discussions at NIRB on 10 March 2020 featured the potential for healthcare students to contribute directly to the pandemic response.

119. On 11 March 2020 at my CNO’s Summit in Birmingham, NHS England's Chief Executive Officer announced that student nurses would be deployed as part of the pandemic response. On the next day, I discussed with the Chief Nurse of HEE and the Chief Executive of the NMC the legislation and NMC education standards for nurses and midwives that could be used and applied to support the deployment of student nurses to healthcare providers.

120. Joint working between the UK CNOs, the NMC, the Council of Deans of Health, the RCM and RCN led to the 12 March letter which outlined the intention to work together on the student deployment proposal **[RM/004] [INQ000283205]**.

121. Throughout early to mid-March 2020 there were numerous discussions between all key stakeholders (including the views of students) relating to the practical, legal and clinical considerations to enable nursing students to join the workforce on a temporary basis. I co-signed a joint statement on 19 March 2020 outlining the proposal to change the education programme for undergraduate nursing students so that they could choose to have a clinical placement as the final six months of their programme **[RM/020] [INQ000232032]**.

122. A further joint statement on 25 March detailed the proposed approach for first year students to continue with their nursing and midwifery programme, while second and third year students (those not in the final six months of their education) would be invited to opt-in to an arrangement to spend 80% of time in paid clinical practice **[RM/021] [INQ000417725]**.

123. On 27 March, three publications from HEE were distributed to support students, including a joint letter to students from HEE's Chief Nurse and me **[RM/022] [INQ000292704]**.

124. 31,000 nursing students opted into paid placements, of which 23,000 ultimately took up paid placements for which I shall be forever grateful. The majority were final year students, but 60% of second year students also opted into paid placements. These students played an invaluable role in responding to the pandemic and, as noted in the Nursing 7 Point Plan Review, the majority of students who took up these placements felt that it was a positive experience.

125. As the clinical need altered, the NMC decided on 7 May 2020 that the original proposal to open the temporary register to final year nursing students would not proceed. It was also agreed with the NMC that no more paid placements would be offered after 31 July 2020 and that paid placements would be brought to a close ready for the new academic year of 2020/21. Additionally, following agreement by their Council members, the NMC took the decision to withdraw the emergency standards with effect from 30 September 2020 **[RM/023] [INQ000421213] [RM/024] [INQ000421239] [RM/025] [INQ000232028]**.

126. Following concerns over increasing Covid-19 cases in the autumn of 2020, I discussed the position on students with UK CNOs, HEE and the NMC and we agreed a statement outlining our position, which was published on 23 November. This statement confirmed that we were not planning any return to the previous emergency standards **[RM/026] [INQ000421189]**.

127. However, as Covid-19 rates continued to increase due to Wave 2, discussions took place between NHS England, DHSC and HEE on workforce capacity. On 23 December 2020, NHS England raised the risk that the capacity of the NHS workforce would come under significant pressure with resultant impact on patient care.

128. HEE led on the discussions with trade unions, the Council of Deans of Health and the NMC on the practical implications of a further deployment of students. Issues raised included universities being closed for Christmas, which meant students being unable to start deployment for 3-4 weeks. Discussions also covered the need for a set contract to ensure consistency, pastoral support and any request being made on voluntary basis.

129. The HEE Chief Nurse outlined the agreed position regarding student deployment in a paper to NIRB on 6 January 2021. I discussed this position with the NHS England Executive Team on 8 January 2021 in the context of the increasing pressures faced by the NHS. Taking the full range of issues into account, NHS England signalled support for exploring how nursing students could once again be deployed in paid placements to help respond to Covid-19 and winter pressures **[RM/027] [INQ000421214]**.

130. Following further discussions with the NMC, NIRB requested that this option be explored by the SSHSC. The SSHSC agreed and made a formal request to the NMC on 13 January to reinstate emergency standards to facilitate final year nursing students to support the NHS workforce. **[RM/028] [INQ000299755]**

131. The NMC agreed to this request and put in place further emergency standards, which were not mandated and allowed for local Trust decision making according to their workforce needs and ability to maintain supernumerary placements. Taking the learning from Wave 1 into account, a consistent 12-week contract was agreed for the majority of students which would bring these arrangements to a close in May 2021.

132. As the numbers of Covid-19 patients in hospital reduced due to the impact of non-pharmaceutical interventions introduced on 4 January 2021 and the vaccine programme, many areas took the decision to maintain supernumerary placements with a focus on enabling students to graduate on time and join the workforce. In total, 5,247 nursing students took up paid placements in this period, a far lower figure than in Wave 1.

133. The option of deploying nursing students in the context of Wave 3 was explored in December 2021. This option was not pursued due to the risk to students' education

and the implication for supply trajectories of newly registered practitioners into the health and care sector. Nursing students were asked to consider joining the vaccine effort in addition to their studies through their local organisation's staff bank **[RM/029] [INQ000421215]**.

134. Due to the nature of midwifery clinical practice, it was not considered appropriate to open the emergency register to midwifery students during the Relevant Period. They continued to work in supervised clinical practice, although some midwifery students did take up the option of additional clinical work separate to their professional training, primarily in healthcare support roles.

Nursing and midwifery staff in non-frontline roles

135. A large percentage of NHS leadership and management roles are filled by registered professionals. This group of professionals was considered as a resource in the event of workforce shortages from early March 2020 and formed part of the discussions at the NIRB meeting of 10 March 2020.

136. I discussed how registered nurses in NHS England and HEE could be asked to help in frontline roles with the HEE Chief Nurse on 3 March 2020. A further discussion with my DCNO team on 9 March 2020 highlighted some of the regulatory issues and related training needs that would need to be considered if this group of staff were to be able to help.

137. On 20 March 2020, HEE's Chief Nurse and I wrote to all registered nurses within NHS England and HEE requesting them to consider returning to clinical practice. I also wrote to clinical colleagues working in academia to invite them to consider returning to practice or supporting through a range of indirect care roles such as working with placement students **[RM/030] [INQ000421216] [RM/031] [INQ000421242]**.

138. As noted in the Nursing 7 Point Plan Review, it is difficult to quantify the exact numbers of staff from these groups who returned to frontline duties in Wave 1, though I know of numerous instances of this happening. The evidence known to us at the time about the number of staff that this group could potentially provide for the NHS and the situation we were facing meant that it was important to make this call for support.

139. A specific request to work in frontline services in Wave 2 was not repeated for this group of nurses and midwives, but the ability to apply to do this remained open

through the wider BBS programme. I know that many of my colleagues from the Nursing Directorate volunteered to join the vaccine programme in Wave 2, including myself and the majority of my senior leadership team.

International recruitment

140. Nurses trained outside the UK are a vital element of our workforce and international recruitment has always been an integral part of NHS workforce planning. This recruitment route was already being enhanced as part of the Government's 50,000 Nurses Programme (which was subsequently delivered six months early in September 2023) and the needs of the pandemic saw an acceleration to help meet immediate and long-term workforce needs.

141. The process for recruiting internationally educated nurses has long been established within the NHS. Recruiting organisations have to adhere to the UK's code of practice for the international recruitment of health and social care personnel, which is based on the World Health Organization's ("**WHO**") code, to ensure that the process is ethical. Prior to the pandemic, between 5,000-6,000 internationally educated nurses joined the NHS annually.

142. The initial ambition for international nurse recruitment to the NHS as part of the 50,000 Nurses Programme was for an additional 18,100 full time equivalent nurses to be in post by September 2025 (subsequently changed to March 2024), with the retention workstream proposed to deliver an additional 13,000 and a further 19,000 to come from increased domestic supply and apprenticeships. However, the pandemic led to immediate challenges for international nurse recruitment, for example:

    a. restrictions on international travel prevented international nurses from travelling to England;

    b. key recruitment countries such as the Philippines were not permitting qualified nurses to leave their countries due to the pandemic; and

    c. as of 24 March 2020, UK objectives structured clinical examination ("**OSCE**")[6] centres closing in line with wider Government restrictions until 2 July 2020.

143. In the context of a rapidly developing need for a skilled workforce to support the pandemic response, focus shifted to what could be done in relation to international

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[6] OCSE is a competency test used to assess candidates against the NMC's UK pre-registration standards for nursing and must be completed by individuals who want to join the NMC register from overseas or after a long period away from practice.

nurses, in spite of these challenges. My team assessed the number of internationally educated nurses who were in England and had:

a. completed all parts of their NMC registration process apart from the final OSCE; and

b. an OSCE booked between March and June 2020.

144. It was estimated that around 3,000 internationally educated nurses were in this position. It was assessed that this group, all of whom were qualified nurses in their home countries and many of whom were working in the NHS in HCSW roles whilst preparing to become registered nurses, could play an important role in the pandemic.

145. My DCNO with leadership responsibility for International Recruitment initiated discussions with the NMC on 23 March 2020 in relation to the potential emergency registration of this cohort to support the pandemic response. I discussed this proposal with the NMC Chief Executive and UK CNOs on 25 March and the proposal was supported.

146. This proposal was approved by NIRB on 30 March 2020, including covering the costs of the nurses' salary and additional support. The NMC agreed to open the temporary register to these internationally educated nurses, announcing this via a joint statement with UK CNOs and trade unions on 2 April 2020 **[RM/010] [INQ000421217]**.

147. The NMC wrote to 2,296 internationally educated nurses on 6 April 2020, inviting them to join the temporary register. By 14 April, 1,292 had already joined the temporary register in England; 9.3% indicated they had expertise in Accident & Emergency and 17% in intensive care. A further 400 internationally educated nurses were invited by the NMC to join the register on 20 April.

148. To support further registration, my team conducted a rapid data collection on 22 April to identify additional internationally educated candidates who were available to join the temporary register. This further cohort were invited to join by the NMC on 30 April 2020. By 22 May 2020, 2,250 internationally educated nurses had joined the temporary register.

149. These colleagues played a vital role in meeting the challenge of Wave 1 and as many were already working within the NHS in HCSW roles they were deployed quickly, usually within their employing organisations.

150. By 21 December 2020, following the reopening of OSCE centres in July, 99% of these temporary registrants had taken an OSCE and were on the full register. My team worked with Trusts to support new international recruits via pastoral and induction masterclasses and online resources to provide and spread best-practice.

151. On 3 December 2020, NHS England approved a further £19 million funding to support additional international nurse recruitment for the rest of 2020/2021 as part of an £80 million package to increase the NHS workforce to tackle Wave 2. DHSC approval for this funding was secured on 10 December and a letter was sent to NHS organisations outlining these plans on 15 December **[RM/032] [INQ000421193]**.

152. Wave 2 led to renewed concerns over the strain likely to be placed on the NHS. While funding for additional internationally educated nurses had been agreed, the standard processes to enable their registration and employment, which can take up to 12 weeks to complete, would have meant that many would not be able to be deployed quickly enough to support managing this challenge.

153. With this in mind, on 29 December 2020, the CPO and I made a joint request to the Director General of NHS Policy and Performance at DHSC to ask the NMC to re-open their emergency register for internationally educated nurses who had booked in an OSCE between January and April 2021. The NMC agreed to this request from DHSC by letter on 31 December and a joint statement from the NMC and UK CNOs on 5 January 2021 announced this change **[RM/033] [INQ000300102]**.

154. This step ensured that 1,732 additional internationally educated nurses who had arrived in England over the previous months as part of our ongoing recruitment processes could be rapidly deployed to the frontline. As was the case with those temporarily registered in Wave 1, the vast majority of these nurses were able to join the full register over the course of 2021. This boost in workforce numbers was supported by other measures, including providing funding to Trusts to cover testing and quarantine regulations introduced for arrivals who may have been traveling from then amber or red Covid-19 travel restriction list countries from February 2021 and the subsequent exemption from hotel quarantine agreed by the Government in April 2021 for arrivals from red travel list countries.

155. Alongside the rapid deployment enabled by the reopening of the temporary register for internationally educated nurses already in England, the targeted funding agreed in December 2020 enabled Trusts, supported by existing national campaigns and programmes, to recruit international nurses and facilitate their arrival and onboarding.

This supported the arrival of an additional 2,800 nurses between February and April 2021.

156. The targeted funding provided to all Trusts was used to increase pastoral care for internationally educated nurses. This included the release of £50,000 for each Trust undertaking international recruitment to support the additional pastoral care costs associated with Covid-19 in March 2021. Costs included:

   a. onboarding – including access to technology and accommodation;

   b. quarantine and testing requirements of new arrivals;

   c. costs associated with joining the NMC Temporary Register;

   d. induction – including access to specific training for international staff, welcome initiatives and pastoral lead resource;

   e. education – access to career development support and skills gap analysis activities;

   f. health and wellbeing; and

   g. OSCE training – strengthening infrastructure, including practice educator resource.

157. The temporary registration process established in January 2021 was re-introduced in Wave 3 on 22 December 2021 to support the NHS as the Omicron variant led to a sharp increase in Covid-19 cases. The NMC's temporary register was re-opened to a cohort of internationally educated nurses to support this response and 602 nurses joined. As with previous waves, the majority (567) subsequently joined the register permanently.

158. International nurse recruitment has been a success. Since September 2019 (which was the baseline data point for this programme), around 87,000 internationally educated nurses have joined the NHS.[7] An average of almost 2,000 internationally educated nurses were recruited each month in 2023/24, supporting the pandemic recovery, although that number has now started to reduce as the 50,000 nurses programme has come to an end.

[7] February 2024 statistics. This includes only those recorded as part of the Electronic Staff Record.

159. Building on the 8,300 internationally educated nurses who joined the NHS between September 2019 and March 2020, throughout 2020/21 and 2021/22, 32,102 internationally educated nurses registered with the NMC and joined the NHS in England (11,232 in 2020/21 and 20,870 2021/22). A further 46,600 internationally educated nurses joined Trusts in England between April 2022 and February 2024.

160. The Nursing 7 Point Plan Review found that internationally educated nurses felt that the process to get onto the temporary register was quick, clear and straightforward. The review also found that they felt that they had "*received appropriate supervision and pastoral support throughout the process and described it to be a valuable learning experience which gave them the opportunity to improve their confidence and skills ahead of their OSCEs and they felt a strong sense of pride be work on the frontline during the pandemic*" *[sic]*. Our international colleagues have had a positive impact on the NHS' ability to support the pandemic response and restore services, as they account for over 90% of the increase in overall nursing workforce since September 2019.

Healthcare support worker programme

161. As with internationally educated nurse recruitment, another ongoing programme to recruit HCSWs was accelerated over this period to support the response to Covid-19.

162. HCSWs play a vital role in the delivery of healthcare to patients across the NHS. They support patients with personal care, mobility, meal times and take observations of patients, including temperature, pulse and weight; other care activities and responsibilities will vary across care settings. The HCSW programme was originally agreed in September 2019 and as at December 2019, there were 144,983 HCSW in the NHS in England, with and 8,931 vacancies.

163. To further support the NHS as the pandemic progressed, proposals for enabling former HCSWs with experience to return to the NHS were first developed by my Nursing Workforce team on 26 March 2020. This work consisted of an advertising campaign and completion of a survey by people interested in becoming a HCSW, followed by screening and employment checks in advance of deployment. This campaign, which ran until early June 2020, saw over 4,500 experienced HCSWs register an interest in returning to the NHS. As with all returning staff, the BBS team were responsible for deployment to NHS organisations; I am unaware of the exact number of these staff who were deployed.

164. Building on this, my HCSW programme team developed plans to accelerate the existing HCSW programme, which were agreed at NIRB on 29 June 2020. As outlined in NHS England's Second Module 3 Statement, these plans were implemented from September 2020, supported by significant funding of £60 million covering 2020 to 2022.

165. Thanks to this work, as at January 2024 the NHS in England had 163,264 HCSWs in post, the highest number ever recorded, compared to 142,501 in January 2019. These colleagues have played an integral role in supporting the pandemic response and recovery and will continue to be an integral part of the NHS's Long Term Workforce plan. To provide career development within the NHS, we have created pathways to support the transition into registered nurse, nursing associate and midwifery roles.

Safe deployment of nursing and midwifery staff

166. Both as an organisation and personally, we recognised that staff would face difficult situations and work in unfamiliar settings and roles during the pandemic. The letter from the UK CNOs, RCN, RCM and the NMC on 12 March 2020 recognised that the pandemic could lead to changes in professional practice and the NMC would take this into account in its regulatory approach **[RM/004] [INQ000283205]**.

167. Considerations for the safe deployment of NHS staff were part of NHS England's response from the start. This work, led and coordinated by the People Directorate, covered both the deployment of returning and new staff and the internal redeployment of existing NHS staff. The following are exhibited:

    a. *COVID-19 Deploying our People Safely* published by NHS England (April 2020) (**[RM/034] [INQ000421218]**), which summarises the key considerations for the safe redeployment of staff and deployment of those joining the NHS in temporary support of our existing workforce. It covered:

        i. principles to consider when deploying staff into settings and roles which are unfamiliar to them;

        ii. consideration of the issues facing each professional group;

        iii. consideration of issues relating to additional capacity from returners, students and volunteers;

        iv. position of the professional regulators;

v. advice on inductions;

vi. training resources; and

vii. indemnity arrangements.

b. *Stakeholder information pack on our response to Covid-19* published by the NMC (21 April 2020) (**[RM/035] [INQ000421243]**), which provided guidance on deployment of those on the NMC's temporary register, arrangements for students and clinical placements, advice on supporting professionals on the permanent register, and other issues.

168. This specific advice was complemented by wider work to support Trusts to deploy their staff safely. For example, as part of my professional leadership role, I wrote to senior nurse leaders in Trusts on 19 March 2020 in my Four Point Plan letter outlining the actions being coordinated with the other UK CNOs and the NMC to increase nursing capacity in the face of the pandemic.

169. The two main guidance documents, "*Redeploying your secondary care medical workforce safely*", initially published on 26 March 2020 and updated on 9 July 2020; and "*Redeploying our people safely*" published on 4 April 2020 and updated on 13 and 30 April 2020 outline the key considerations to support local trust decision making when redeploying their staff **[RM/036] [INQ000269959] [RM/037] [INQ000269941]**.

170. This work was coordinated by the People Directorate and covered all NHS staff. My team, led by my DCNO for Policy and System Transformation, provided comments on draft documents and these were shared for approval at NIRB meetings which I attended.

171. In advance of the wider work on safe deployment of staff, and in response to the projections of critical care capacity being exceeded as per the reasonable worst case scenario, my team coordinated joint working through a task and finish group to deliver "*Coronavirus: principles for increasing the nursing workforce in response to exceptional increased demand in adult critical care*". This guidance, which was drafted by specialist critical care organisations with input from the 4 UK nations, the NMC and trade unions, was cleared by NIRB on 23 March 2020 and published on 25 March, along with a joint statement from UK CNOs, RCN, NMC, Unison and the specialist critical care organisations **[RM/038] [INQ000421219] [RM/039] [INQ000227427]**. The guidance advised that in the event of a

doubling/trebling/quadrupling of Intensive Treatment Unit ("**ITU**") capacity, as was being predicted by modelling at that time, a team approach should be taken to staffing ratios to allow the experienced critical care staff to concentrate on the technical/clinical aspects of care delivery. In theory, this meant that to ensure as many patients with Covid 19 as possible could receive critical care at times when units were under extreme pressure in terms of demand, units could implement a ratio of up to one trained critical care nurse for six level 3 patients, with support from four other registered nurses and a further team of four HCSWs.

172. As outlined below in Paragraph 182, the impact of the pandemic on staff working in critical care was significant. In preparing guidance to support local organisations in Wave 2, we took this into consideration and outlined revised critical care nursing ratios in "*Advice on acute sector workforce models during COVID-19*", published on 10 December 2020 **[RM/040] [INQ000269986]**. This guidance advised that Trusts should maintain staffing ratios at a minimum of one critical care nurse to two level 3 beds[8] and that this should not be exceeded unless local and regional mutual aid options have been explored, exhausted and escalated appropriately.

173. During Wave 1, NHS England did not collect data on whether Trusts were able to maintain recommended staffing ratios in critical care, but were able to assess impact and issues through intelligence gathered by regional teams. From late 2020 onwards, I received regular reports from NHS England's EPRR team on Trusts who were struggling to maintain recommended critical care ratios to enable support to be offered through regional teams.

174. Learning from the pandemic was built into NHS England's document "*Winter preparedness: Nursing and Midwifery Safer Staffing*" first published on 12 November 2021. This guidance outlined how Trust boards should support safer staffing, including in critical care, through a series of actions focused on preparedness, decision making and escalation processes **[RM/041] [INQ000421208]**.

175. As the NHS continues to recover from the impact of the pandemic, there have been calls for more flexibility in the ratios for nursing staff in critical care settings. Whilst I fully support implementing learning from the pandemic in relation to more multi-professional teams in ITUs, such as pharmacists and respiratory physiotherapists, I

[8] Level 3 critical care is used for patients requiring advanced respiratory support (ventilation) alone or in combination with support of other organs. This level includes all complex patients requiring support for multi-organ failure. Also known as 'intensive care units' ("ICU") or 'intensive treatment/therapy units' ("ITU").

strongly feel that the experience of the pandemic shows that the recommended 1:1 patient/nursing ratios for level 3 critical care beds are necessary for both patient care and staff wellbeing. I continue to support these ratios, while appreciating the need for a degree of flexibility in exceptional circumstances such as those we faced in the pandemic.

Health and wellbeing of nurses, midwives and HCSW

176. The health and wellbeing of nurses, midwives and HSCWs has always been important to me but the impact of Covid-19 heightened the importance of this work.

177. This issue was highlighted as an area of concern during my regular system-wide nursing leaders call on 13 March 2020. It continued to be raised with me through my discussions with frontline staff via my CNO SAG, CNO BME SAG and National Shared Decision Making Council meetings, as well as on the regular webinars with nursing and midwifery colleagues across the NHS. My team also heard first hand about the impact of managing Covid-19 patients on nurses from our Italian nursing colleagues on 31 March 2020, who had sadly been ahead of us in managing the first wave of the pandemic. The importance of psychological support for staff was a key theme of this discussion.

178. These concerns were of course not unique to nursing, midwifery and HCSW. A similar impact was being felt across all of our professions. As outlined in NHS England's Third Module 3 Statement, building on existing work, the Workforce Cell coordinated a national health and wellbeing support offer for staff in NHS organisations, in light of the extraordinary situation.

179. This programme was launched by the CPO on 8 April 2020 and a large number of initiatives and activities to support our staff were delivered under the three programme workstreams of:

    a. psychological wellbeing, including mental health support;

    b. physical welfare, including childcare, transport, accommodation, food, terms and conditions and finance; and

    c. occupational health.

180. Notwithstanding this extensive work, I was concerned with the feedback I had been hearing from nurses about the pressures they had been under from working in the pandemic. I had experienced some of these pressures myself, working on the

frontline during April and May 2020 (see Paragraph 67 above). I also knew that even before the pandemic, mental health related sickness was the largest cause of absence in the nursing workforce.

181. I wanted to do something specifically for nurses, along the same lines of the established NHS Practitioner Health programme which had supported doctors and dentists for a number of years. I asked my Head of Mental Health Nursing to draft a proposal for a health and wellbeing offer to nurses as a basis for discussion with the CPO and her team in May 2020.

182. As this work was being developed, further evidence specific to the impact of the pandemic on critical care nurses' health and wellbeing was emerging. Work led by Professor Kevin Fong, based on surveys of critical care staff, was shared with me via the CPO Directorate on 30 July 2020 and showed that working in intensive care during the pandemic was having a significant impact on mental health and wellbeing, particularly for nurses, to the extent that it could potentially be impacting on patient safety **[RM/042] [INQ000421181] [RM/043] [INQ000421182] [RM/044] [INQ000421183]**.

183. Further surveys coordinated by Professor Fong continued to reinforce this picture. I wanted to ensure that the offer being developed for nurses would have a specific, targeted element for intensive care nursing staff.

184. Following discussions with the CPO and National Director for Mental Health, where concerns over replicating the NHS Practitioner Health programme were raised, plans for a mental health offer for nurses were refined and expanded to incorporate wider workforce groups who needed support, including paramedics, pharmacists and therapists. This proposal, backed with a £15 million funding package, was announced on 20 October 2020 to sit alongside the wider NHS health and wellbeing offer **[RM/045] [INQ000421238]**.

185. This package consisted of:

   a. creating a national support service for critical care staff who research suggested are most vulnerable to severe trauma;

   b. funding nationwide outreach and assessment services, ensuring staff receive rapid access to evidence based mental health services; and

   c. developing wellbeing and psychological training, which was rolled out over the winter of 2020/21.

186. As part of this work, a bespoke offer to support intensive care nurses was also agreed, which launched in March 2021. This is the Professional Nurse Advocate ("**PNA**") programme, which is a clinical model of restorative supervision for nurses in England. PNA-trained staff listen to and understand the challenges fellow colleagues and teams are facing, and provide and deliver quality improvement initiatives in response.

187. Although this started as a critical care initiative, it was expanded due to its success. As of March 2024, over 4,400 PNAs had completed training, of which, around 500 are in critical care. 10,033 PNA training places have been commissioned by NHS England between 2021-2024. Since April 2022, PNAs have delivered around 54,363 sessions of restorative clinical supervision and 34,105 career conversations. They have also been involved in over 2,700 quality improvement projects each month.

188. The PNA role and programme resulted in increased staff satisfaction, improvements in working relationships and improvements in staff health and wellbeing through earlier intervention, signposting, and access to support. Feedback on the programme showed that it had a positive impact on those who accessed it across England in supporting them in working towards a safer and more motivated team, improving staff mental health and wellbeing, promoting collaborative teamwork, and reducing stress and burnout **[RM/125] [INQ000477796]**.

189. To date the Nursing Directorate has invested over £8 million in commissioning PNA training places, and a further £1 million, to support effective implementation through the recruitment of regional PNA advisors, continual professional development and research and evaluation. It continues to be a key part of my vision for nursing, is included in safer and effective staffing guidance, and is specifically referenced in the NHS standard contract.[9] To specifically support maternity and neonatal services, in August 2023 we announced further funding of £4 million for Professional Nursing and Midwifery Advocates in these settings.

190. The risk assessment process established for NHS staff was led by the Workforce Cell, with the CPO as executive lead. Full details of this work is outlined in NHS England's Third Module 3 Statement, however in summary:[10]

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[9] This form of contract is mandated by NHS England for use by commissioners (NHS England and ICBs) for all contracts for NHS funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services).

[10] As requested by the Inquiry, a summary of the material from NHS England's Third Module 3 Statement has been included, however, not all of this material is within my direct knowledge.

a. On 15 April 2020, following press reports, emerging evidence and anecdotal information from across the NHS on the disproportionate impact of Covid-19 on people and in particular staff from Black, Asian and minority ethnic backgrounds, NHS England's Chief Executive Officer held a summit of leaders in healthcare and representative bodies such as the British Medical Association and RCN to agree a plan of action to support staff, which I attended. Immediately following it, he commissioned the CPO to lead the work to consider the NHS response and on 16 April 2020, the CPO established the Black, Asian or minority ethnic staff workstream within the Workforce Cell.

b. An intense period of work followed the establishment of the workstream to develop a plan in response to the growing fears and concerns of Black, Asian or minority ethnic staff with regards to Covid-19. A workforce update was presented for discussion at the 24 April 2020 NIRB meeting **[RM/126] [INQ000330848]** which highlighted that NHS England had developed an action plan. The need to provide guidance and support to employers on proactive approaches to risk assessing existing and returning Black, Asian or minority ethnic staff was noted.

c. On 29 April 2020, CEO and COO wrote to the NHS stating that as a precautionary step, organisations were recommended to risk assess staff at potentially greater risk and make appropriate arrangements accordingly **[RM/127] [INQ000087412]**.

d. Working with NHS England, NHS Employers published the first version of the Risk Assessment Guidance on 30 April 2020 **[RM/128] [INQ000330983]** which was updated over time including on 14 July 2021 **[RM/129] [INQ000331022]**.

e. On 12 May 2020, an independent publication was produced, supported by NHS England, entitled the "*Risk Reduction Framework for NHS Staff at risk of Covid-19 infection*" **[RM/130] [INQ000223041]**.

f. The Risk Assessment Delivery Unit was established on 6 July 2020, which was a team of staff brought together to support the regional and local process of risk assessments across England, in line with local guidance and NHS Employers' published Risk Assessment Framework. A more detailed email with accompanying technical FAQs document was sent out by the CPO on the same day **[RM/131] [INQ000330873] [RM/132] [INQ000330874]**.

g. NIRB was provided with updates and the work around risk assessments developed overtime, including considerations regarding the limitations of data collected.

191. I fully supported implementation of this process, as the issue of the disproportionate impact of Covid-19 on Black, Asian and minority ethnic staff had been raised with me at an early point in the pandemic (see Paragraph 60 above and paragraphs 207 to 217 below).

192. When the issue of the risk assessment for Black, Asian and minority ethnic staff was discussed at NIRB on 19 June 2020, my feedback was that the pace of implementation should be increased, from the proposed 4 weeks to 2 weeks. This was agreed and reflected in the letter to Trust CEOs and Chairs **[RM/046] [INQ000051089]**.

193. By way of reflection, while we were able to support the NHS by employing additional staff on either a temporary or permanent basis through the Relevant Period, much of the weight of providing care for patients with Covid, particularly in Wave 1, was carried by staff who were redeployed from their usual roles.

194. The impact of the pandemic on all staff was massive. As outlined above, I played a role in NHS England's strengthened health and wellbeing offer for NHS staff and I was able to start the PNA programme for nursing staff in critical care to access a specific programme of support.

Staff testing and isolation

195. As outlined in NHS England's Second Module 3 Statement, the operational elements of testing led by NHS England were coordinated by the NHS Testing Cell. These offers were made to all appropriate healthcare staff as capacity allowed, rather than being rolled out in specific professional groups.

196. My involvement in this area was mainly from a national and professional leadership perspective, focused on inputting the nursing view (including advocating for specific groups such as nurses in ITUs to be prioritised on 19 March 2020 at a time when testing capacity was limited). It was also shaped by my leadership of operational IPC issues, an area in which patient testing played a vital role (see Section 4).

197. In terms of the rules relating to self-isolation for healthcare staff, these were decisions taken by DHSC and PHE/UKHSA based on the latest scientific evidence. I attended meetings with DHSC leads where these issues were discussed, mainly the Senior

Clinicians' Group chaired by the CMO for England. I also attended meetings within NHS England where operational issues were discussed. I was not involved in the decision making by the Government in this area.

198. Concerns about the operational impact of self-isolation were generally raised through senior operations leads within Trusts, however:

a. I was aware of concerns from frontline organisations of the impact of self-isolation of healthcare staff from internal discussions at Strategic Fusion meetings. These issues were particularly discussed in:

i. early June 2020 as the Test and Trace isolation requirements were being introduced;

ii. the autumn of 2020 as cases increased and staff were required to isolate and/or provide childcare for their school age children who had tested positive; and

iii. the summer of 2021 as cases increased.

b. A shortage of midwives in a number of organisations due to self-isolation was raised with me on 22 July 2021. I took this issue to Strategic Fusion for discussion on 23 July and also discussed this with maternity colleagues on the same day. Actions from these discussions were developed into the maternity and neonatal services action plan, published by NHS England on 10 August 2021 **[RM/051] [INQ000421229]**.

199. NHS England's role in relation to self-isolation was mainly one of supporting awareness and implementation of the requirements and supporting Trusts to manage any operational issues that may have arisen. I was a joint signatory, along with the National Medical Director and Chief Operating Officer, to the letter of 9 June 2020 "*Minimising Nosocomial Infections in the NHS*", which outlined the position for NHS staff in terms of 14 day self-isolation as per NHS Test and Trace requirements if they were a contact of a positive case. This letter also outlined the steps that NHS England asked Trusts to take to minimise the potential impact of staff absences **[RM/047] [INQ000088724]**.

200. I also co-signed, along with the National Medical Director, CPO and National Director for Urgent and Emergency Care, the follow-up letter dated 24 June 2020, which outlined that surplus tests could be used on asymptomatic staff in organisations or areas where there was an outbreak or high prevalence of Covid-19. In both of these

letters, my main input was focused on the IPC elements, but I approved the full content of the letter along with my colleagues as part of a collaborative approach **[RM/048] [INQ000145891]**.

201. In my professional leadership role, I wrote, together with NHS England's National Medical Director, to system leaders to outline the developing plans for further staff testing. This outlined an expansion in testing for all patient facing staff in areas of England designated by the Government to be in 'tier three' of their local tiered restrictions system **[RM/049] [INQ000421187]**.

202. Due to expanding testing capacity, this letter was quickly superseded by an announcement on 9 November 2020 that all NHS staff would be included in an asymptomatic testing programme **[RM/050] [INQ000348581]**.

203. On 11 December 2021, the Government announced that the self-isolation requirement for contacts of positive Covid-19 cases would reduce from 14 to 10 days. Following a clarification request, after my team noticed that UKHSA guidance on this had changed back from 10 days to 14 for healthcare workers, it was confirmed by the CMO via our Testing Cell that the 10 day isolation requirement would apply to health and social care workers and this was subsequently amended in the UKHSA guidance.

204. To support understanding of the UKHSA guidance amongst nurses and midwives and in my role to support the operationalisation of UKHSA guidance, I signed a letter to NHS organisations dated 16 December 2021 confirming this advice from UKHSA **[RM/052] [INQ000421200]**.

205. However, within a week this advice had been amended by UKHSA to allow NHS staff to return to work after 7 days if they tested negative on two consecutive days. I co-signed a further letter dated 23 December 2021 to NHS organisations outlining this change **[RM/053] [INQ000421201]**.

206. Testing played a vital role in keeping staff and patients safe and the growing increase in the availability of polymerase chain reaction ("**PCR**") tests and subsequently lateral flow device ("**LFD**") tests from the end of Wave 1 were a vital tool in the recovery of services. From my perspective, this was particularly important in terms of implementing IPC measures to keep patients safe.

Equalities

207. I have a deep commitment to developing a nursing and midwifery leadership which reflects the diversity of the whole workforce. Prior to the pandemic, my team with a focus on Ethnic Minority Nursing had designed a leadership development programme for Black, Asian and minority ethnic nurses and midwives in the NHS. My team continued its work as the pandemic developed, and this became the CNO Ethnic Minority Action Plan in July 2020, which dovetailed with wider work in the NHS led by the CPO.

208. As outlined in Paragraph 60 above, working with the CNO and CMidO BME Strategic Advisory Group and Workforce Racial Equalities Standard ("**WRES**") team, the Nursing Directorate was able to engage over 1,600 nurses and midwives to undertake listening events in April and May 2020.

209. As highlighted above, the disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities was something that I was aware of at an early stage. It was raised with me for the first time directly by the then Director of the WRES Implementation Team on 7 April 2020 in the context of reported staff deaths. Earlier on the same day, a letter from the British Association of Physicians of Indian Origin, addressed to the NHS Chief Executive Officer, CMO and NHS England's National Medical Director and copied to me, also raised this issue **[RM/054] [INQ000148477]**.

210. I asked NHS England's National Medical Director, CPO and the Strategic Incident Director for Covid-19 on the morning of 8 April 2020 whether this issue was being explored further. It was discussed at that morning's Strategic Fusion meeting. I also wrote to the NMC on the same day asking whether applications from returning staff collected information on their ethnicity, given these growing concerns **[RM/055] [INQ000421165] [RM/056] [INQ000099533] [RM/057] [INQ000421167] [RM/058] [INQ000421168] [RM/059] [INQ000421164]**. They responded saying that they were looking at capturing this data and were able to provide NHS England with summary information on the ethnicity of returners over Wave 1 by early September **[RM/133] [INQ000477791] [RM/134] [INQ000477792]**

211. On the following day, NHS England's National Medical Director and I raised this issue at the Senior Clinicians' Group and the CMO commissioned PHE to look into this issue. PHE's work led to the publication of their report on the impact of Covid-19 on Black, Asian and minority ethnic groups, published 16 June 2020.

212. The listening events organised with the CNO BME SAG in April and May 2020 were instrumental in further highlighting this issue. These events also identified the issue of the lack of variety in FFP3 masks, as many Black, Asian and minority ethnic staff were reporting issues with fit testing (see Section 4). This led the DCNO for Patient Safety and Innovation to examine it, which led to it being raised with the DHSC in relation to their role in providing PPE to the NHS and the development of tools to support safe FFP3 use for NHS staff.

213. The CNO Ethnic Minority Action Plan, which was agreed by my senior management team in July 2020 brought together pre-pandemic work with the new challenges of the pandemic. This work complemented the NHS-wide work led by the CPO team, as well as providing a nursing and midwifery specific perspective.

214. The CNO Ethnic Minority Action Plan is fully established as an important part of the Nursing Directorate's work and has delivered:

    a. A guide (with NHS Employers) to help support international nursing colleagues during the pandemic, particularly those who are new to the UK and the NHS.

    b. The Nursing and Midwifery Sponsorship Programme (formerly known as the Getting to Equity Programme) launched as an evidence-based framework that enables executive leaders to promote the careers of aspiring ethnic minority nurse leaders and midwives. As of May 2024, there have been 664 participants (including myself in September 2022).

    c. Anti-racism in professional practice resource, developed with the NMC and NHS Confederation, which aims to raise understanding of what anti-racism means in an individual nurse or midwife's professional practice and ensure that anti-racism is incorporated into future regulatory review and standards setting.

    d. A supported risk assessment process for ethnic minority staff by collating and disseminating good practice examples across regions; also helped to develop NHS Employers guidance on risk assessments.

    e. A joint programme with Shuri Network (a network of women from minority ethnic groups in digital health) to provide support to ethnic minority nurses and midwives in digital health and leadership.

f. The establishment a post of CNO BME Nursing Advisor which enabled a specific focus on the experience of Filipino nurses and midwives during the pandemic. This role was subsequently expanded to also cover wider international recruitment issues.

215. The programme, coordinated by my CNO and CMiDO Ethnic Minority Advisory Collaborative (which brings together the BME Executive Chief Nurses Network, Jabali Men's Network and the CNO BME SAG), continues to engage with Black, Asian and minority ethnic nursing and midwifery staff.

216. As outlined in NHS England's Second Module 3 statement, we have provided direct grant funding support to develop UK based International Nursing and Midwifery Associations ("**INMAs**") to ensure that they are able to provide additional pastoral, professional and health and wellbeing support to international nurses and midwives working in the NHS. Before the pandemic, there were 3 international nursing associations; by 2021 there were 18 international nursing and midwifery associations, covering 15 nationalities; by 2023 this had increased to 28 and at present there are 35.

217. In addition to this work focused on the nursing workforce, my Equalities and Health Inequalities team under the leadership of the Director for People and Communities supported the wider organisation at the early stage of the pandemic by agreeing a simplified Equality and Health Inequality Impact Assessment in March 2020, supported by new guidance and templates. This helped teams across NHS England to rapidly assess the inequalities and health inequalities impact of policies drafted in response to the pandemic and this process was endorsed for widespread use throughout NHS England at the NIRB meeting of 8 July 2020.

Long COVID

218. NHS England established the Long COVID Programme and Long COVID plan to develop care pathways for treatment and rehabilitation, under the leadership of its National Director for Primary Care, Community and Strategy. I ensured nursing involvement in this work from October 2020 through my DCNO for Policy and System Transformation and DCNO for Policy and Strategy, who fed into this work.

219. Given the estimated numbers of the population affected by Long COVID (in March 2022, the Office for National Statistics Survey found 1.7 million people living in private households (2.7% of the UK population) were experiencing self-reported Long COVID), there is undoubtedly an impact on all elements of our NHS workforce.

However, as this is an issue affecting the whole NHS workforce rather than only nurses and midwives, work on the impact of Long COVID on NHS staff during the Relevant Period was led by our People Directorate. I did, however, undertake the following activity in relation to Long COVID and nurses:

a. I attended a Long COVID roundtable convened by the then DHSC Minister Lord Bethell on 16 November 2020. Colleagues from the Nursing Directorate involved in the nursing Long COVID work attended subsequent meetings on my behalf.

b. Following concerns raised directly with me in December 2021, I met with nurses affected by Long COVID on 20 December 2021 and heard first hand of their experiences, covering the clinical model of Long COVID care and HR issues. Colleagues present from the People Directorate took these discussions into account in the development of work to support NHS staff affected by Long COVID and the HEE Chief Nurse (who was also present) provided feedback into the wider Long COVID work led by the National Director for Primary Care, Community and Strategy **[RM/060] [INQ000421203]**.

c. I visited a Long COVID clinic at University College London Hospitals NHS Foundation Trust on 23 July 2022, where I met with the clinical team and spoke to patients to understand the ongoing issues faced by people with Long COVID.

220. To support nurses and midwives to deliver services for patients with Long COVID, my team produced the Long COVID framework for nursing, midwifery, and care staff, which was published on 28 September 2022. This framework was designed as a supportive resource for staff, signposting tools to help everyday clinical practice **[RM/061] [INQ000421207]**.

221. Further information on Long COVID is set out in NHS England's Long COVID statement provided to the Inquiry as part of Module 2 and NHS England's Fourth Module 3 Statement.

SECTION 4: INFECTION PREVENTION AND CONTROL

222. Keeping patients, visitors and staff in healthcare settings as safe as possible was one of the greatest challenges faced by the NHS in the pandemic. NHS England's Third

Module 3 Statement outlines the actions taken by NHS England in relation to IPC. In this section I will build on this with my own perspective and experiences.

223. There were significant challenges over the Relevant Period relating to IPC, including the lack of widespread testing and PPE supply, particularly during Wave 1, as well as the ongoing challenge of adapting our approach in line with what we knew about the virus.

224. This section will cover my role as national Director of Infection Prevention and Control for NHS England,[11] co-chair of the HOCI WG and my national responsibility for NHS England's Covid-19 nosocomial infections programme.

225. In this role, I drew upon on the work of NHS England's IPC team, who provided me with in-house specialist IPC scientific and technical expertise as well as the expertise of PHE/UKHSA (particularly the leaders of their National Infection Service), UK CMOs, the Scientific Advisory Group for Emergencies ("**SAGE**"), the National Medical Director and the UK IPC Cell. This was important to me, as well as to my DCNOs with responsibility for this area, as they were able to provide a clinical expert view on the scientific and operational elements of this work.

226. I also heard views on the operational elements of IPC from the CNO SAG, the RCN, my shared decision making councils, the CNO BME SAG and other individuals and organisations from the frontline who provided me with their perspectives of implementing IPC measures.

227. The IPC specialist leads within the Nursing Directorate were involved in the incident response from the start, joining EPRR daily incident calls from 22 January 2020 and providing daily updates on the developing incident to myself and the DCNO for Patient Safety and Innovation.

228. To offer further support, in February 2020, I approved the release of regional IPC leads from their usual work to support the incident response. Following discussion at NIRB on 3 March, my then Head of IPC arranged specialist IPC nurse input to support the Arrowe Park facility, which provided quarantine for people returning from China.

[11] I assumed the role of National Director of Infection Prevention and Control in Spring 2017, as this aligned with my responsibilities for delivery of the gram negative infections workstream of the Anti Microbial Resistance Programme in my then role as Executive Director of Nursing at NHS Improvement.

229. I met with NHS England's Medical Advisor for IPC (NCD for IPC from November 2020) and the Head of IPC almost every day during the pandemic to discuss IPC. In addition to the expert views of the IPC team, I also heard from a wide range of experts at the HOCI Working Group, including microbiologists and IPC experts from across the country, to ensure that a full range of views were discussed and fed into this work. I will always be enormously thankful for the work that NHS England's team and their specialist IPC colleagues across the NHS put in to support patients and staff at this time.

Covid-19 IPC guidance

230. As set out in NHS England's First Module 3 Statement:

   a. PHE's core role was to fulfil the SSHSC's statutory functions (primarily set out in sections 2A and 2B of the National Health Service Act 2006) to protect the nation's health, address health inequalities and promote the health and wellbeing of the people of England.

   b. Prior to its dissolution on 1 October 2021, and the replacement of its functions primarily by UKHSA and the Office for Health Improvement and Disparities, PHE was the body responsible for providing specialist health protection, epidemiology and microbiology services and advice across England and collaborating with the health protection agencies (providing similar specialised services) in the devolved administrations.

231. A timeline of:

   a. IPC guidance in relation to the pandemic; and

   b. developments in IPC guidance and governance in England since 1998,

   is set out in NHS England's Third Module 3 Statement.

232. NHS England's role in UK IPC Guidance production was through membership of the UK IPC Cell, which brought together IPC leads/specialists from across the UK. Initially the UK IPC Cell provided comments on draft guidance, however, from June 2020 onwards the UK IPC Cell drafted guidance (see Paragraph 230 onwards for details).

233. The membership of the UK IPC Cell included NHS England, PHE, Public Health Wales, Antimicrobial Resistance and Healthcare Associated Infection Scotland, the

Scottish Government, Public Health Agency Northern Ireland, the Association of Ambulance Chief Executives and DHSC. NHS England's IPC team hosted and administered the UK IPC Cell meetings, including organising meetings and recording actions.

234. I was not a member of the UK IPC Cell but members of my IPC team attended. The Cell was chaired by NHS England's Head of IPC from its inception until June 2021, when chairing duties rotated to the Deputy Medical Director of Public Health Wales. The Cell worked collaboratively on a consensus basis, making recommendations and providing draft content for the UK IPC Guidance, which was then passed to PHE/UKHSA for comment and publication approval.

235. The establishment of a cell with a UK-wide focus was enormously helpful in ensuring a consistent UK approach to IPC guidance. This was noted as a positive move which supported consistency in approach in the CMO's *"Technical report on the COVID-19 pandemic in the UK"*.

236. In respect of the Relevant Period, I played no direct role in the production of the UK IPC guidance until late March 2020. Members of my team through their roles on the UK IPC Cell supported this process and kept me updated on progress or changes.

237. My role in the guidance production was primarily to approve drafts on behalf of NHS England. When substantial guidance changes were made, I sought advice from the Senior Clinicians' Group, in advance of organisation-wide approval via NIRB before forwarding to PHE/UKHSA (and in some cases to the CMO) for approval and publication. I also played a role in listening to concerns from Royal Colleges, regional and frontline colleagues about how the UK IPC Guidance was being implemented to feed into the ongoing review process, as outlined below.

238. I do not have the specific scientific and technical expertise, and neither is it my role, to make decisions on issues such as PPE specification and use and the types of disinfectant to use. I sought views from the experts (including PHE/UKHSA) involved in drafting and publishing the guidance in these areas. My perspective was from an operational viewpoint, assessing whether the guidance would be accessible to frontline staff to enable implementation.

239. Similarly, when listening to concerns from stakeholders and frontline staff, if these related to technical or scientific issues, I ensured the concerns were relayed to PHE/UKHSA and the UK IPC Cell and sought assurance that they had been considered.

240. My first direct involvement in IPC guidance production came in late March 2020, when PHE proposed to add four tables to the UK IPC Guidance describing PPE use across different clinical scenarios and settings. PHE drafted the PPE tables for discussion and approval by a wide range of external stakeholders, including the RCN the Academy of Medical Royal Colleges ("**AoMRC**") and senior clinicians.

241. The UK IPC Cell reviewed and agreed the final drafts of the tables on 31 March 2020. I co-ordinated comments and approval from the other UK CNOs, the RCN and AoMRC, which were sent back to PHE. The revised guidance received final sign off from the UK CMOs on 1 April 2020 and was published by PHE on 2 April 2020.

242. As outlined below, in April 2020, a significant amount of work was undertaken to support implementation of the UK IPC Guidance in the NHS in England to prevent nosocomial infections. In terms of the guidance itself, following feedback from frontline staff to the UK IPC Cell and discussions at the HOCI WG on 7 May 2020, the UK IPC Cell accepted a commission to undertake a gap analysis of the current UK IPC Guidance against the latest evidence on Covid-19 transmission. This identified areas of the guidance that the Cell's IPC specialist leads felt could benefit from strengthening, such as ventilation, cleaning and distancing between staff in non-clinical areas.

243. On 11 May, following this gap analysis being shared with the HOCI WG, I wrote to the Director and Deputy Director of the National Infection Service at PHE, setting out these identified gaps in the IPC Guidance and offered to work with PHE on the necessary changes to update the guidance accordingly. The Deputy Director responded later that same day with proposed amendments to the issues raised in the gap analysis and these changes were subsequently made to the UK IPC Guidance published by PHE on 18 June 2020 **[RM/135] [INQ000477784] [RM/136] [INQ000477785] [RM/137] [INQ00047786] [RM/138] [INQ000477787] [RM/139] [INQ000477806]**.

244. Throughout the summer of 2020, work continued to be carried out by the UK IPC Cell in relation to the IPC guidance. The main aim at this time was revising the guidance to support safe restoration of NHS services. The final draft of this revised guidance was shared with internal and external stakeholders, with comments received from DHSC, PHE, the Association of Directors of Adult Social Services and the Royal Colleges. On 13 August 2020, I was told by the Minister for Social Care, that the UK IPC guidance needed to be approved by the Social Care Policy team in DHSC. The publication of the guidance was delayed to allow for this. Subsequently, DHSC chose

to produce their own IPC guidance for social care settings. The revised UK IPC Guidance (not inclusive of guidance for social care in England) was approved and published by PHE on 21 August 2020.

245. As the pandemic progressed through late 2020 and 2021, the IPC guidance was continuously reviewed by the UK IPC Cell and PHE/UKHSA to ensure that it was aligned with the latest evidence on Covid-19. My role in the publication of guidance over the period was limited to providing approval of new versions on behalf of NHS England on operational aspects before the guidance was sent to PHE/UKHSA for publication approval.

246. Following a request from the SSHSC, and along with colleagues in NHS England's Urgent and Emergency Care Directorate, I supported UKHSA's work on thematic IPC guidance to support the restoration of elective services. NHS England provided operational information on the potential impact of changes to IPC guidance to support UKHSA's work in this area. UKHSA's electives IPC guidance was published on 27 September 2021.

247. As noted in a paper I presented to NHS England's Operational Response and Delivery Group ("**OpReD**") on the same day, the UK IPC Cell had already been planning to make similar recommendations for the UK IPC Guidance to establish a position where Covid-19 would be managed in a similar way to other acute respiratory infections. This would enable the majority of hospital care to be delivered using standard IPC measures. These changes and the UKHSA electives IPC guidance were reflected in the version of the UK IPC Guidance published on 22 November 2021 **[RM/062] [INQ000421221]**.

248. As outlined in the NHS England's Third Module 3 Statement, by Spring 2022 NHS England had published the National Infection Prevention and Control Manual for England ("**NIPCM**"), setting out an evidence-based manual for use by all those involved in care provision in England. On 27 May 2022, UKHSA archived the COVID-19 UK IPC Guidance, replacing it with Covid-19 specific advice for health and care professionals, which complemented the NIPCM. This signalled a definitive move towards treating Covid-19 as one of many acute respiratory diseases experienced and managed in the UK **[RM/063] [INQ000421222] [RM/064] [INQ000421245]**.

249. The process of continually reviewing the guidance as new evidence emerged, conducted by both PHE/UKHSA and the UK IPC Cell, ensured that the latest knowledge was assessed by experts as our understanding of Covid-19 developed.

Personal Protective Equipment

250. The issue of the lack of PPE at the start of the pandemic, while understandable given the worldwide demand, caused genuine concern for all healthcare workers.

251. PPE supply was not the responsibility of NHS England, and was not within my remit as CNO. PPE use in healthcare settings was covered in the UK IPC Guidance and related PPE guidance published by PHE/UKHSA during the Relevant Period.

252. However, in both my professional leadership role for nurses and midwives, and via my responsibility for operational IPC issues, I received feedback on PPE. In the early months of the pandemic, feedback was generally focused on supply issues and the impact of shortages of PPE on staff, which caused significant concern. As these supply issues receded (from the summer of 2020), the focus moved to the type of PPE to be used when treating Covid-19 positive patients or suspected to have Covid-19.

253. Given the unprecedented situation and the likelihood of many extremely unwell, infectious patients coming into hospitals (and being seen by healthcare workers in community settings), there was enormous concern amongst NHS staff about PPE. The UK IPC Cell noted this concern coming from frontline staff in early March 2020 as cases began to increase. The PHE representative within the UK IPC Cell stated that there would be a potential change in the approach to PPE as High Consequence Infectious Diseases ("**HCID**") unit capacity was being exceeded and there were meetings with the New and Emerging Respiratory Virus Threats Advisory Group ("**NERVTAG**") and the CMO to make this decision, which I did not attend.

254. On 6 March 2020, following a commission from the CMO for England to PHE to revise the UK IPC Guidance in line with this new approach to PPE, PHE presented a revised version of the guidance to NERVTAG. Following NERVTAG approval, the revised UK IPC Guidance was published by PHE on the same day. This guidance recommended that, outside of intensive care units and other areas where aerosol generating procedures were taking place (such as bronchoscopy, upper gastro-intestinal endoscopy and tracheostomy procedures), fluid resistant surgical facemasks be used. This meant that healthcare staff outside of those defined areas would not routinely use FFP3 masks for confirmed and suspected Covid-19 positive patients. I was not involved in this decision.

255. As the number of patients with Covid-19 in hospitals increased through March and early April 2020, there were increasing reports from frontline staff of PPE supply

shortages. These concerns were discussed at the Senior Clinicians' Group on 9 April 2020. This was at a time when the pandemic was rapidly developing – there were increased hospital admissions and PPE supplies were decreasing. PHE's Deputy Director of the National Infection Service was tasked with drafting guidance on steps to be taken during PPE shortages. This draft was prepared on 12 April and I led an urgent discussion with Regional Chief Nurses and Trust DoNs regarding gown use in advance of a specially convened meeting of the Senior Clinicians' Group on that same day.

256. During that meeting, I stated that I could not support PPE proposals which could potentially impact staff safety. The RCN were aligned with my position and also opposed to any measures which were not aligned with the existing IPC and WHO guidance **[RM/140] [INQ000477782]**.

257. The UK IPC Cell could not endorse such proposals for the same reasons that I had expressed on 12 April. PHE were formally informed of this by the DCNO for Patient Safety and Innovation on 14 April 2020, which confirmed that these were matters for the Health and Safety Executive **[RM/141] [INQ000477783]**.

258. On 17 April 2020, PHE published a version of this guidance: "*Considerations for acute personal protective equipment shortages*" and referenced a number of organisations including PHE, NHS England, Public Health Agency (Northern Ireland) and Public Health Wales. This document advised continued use of masks and re-use of PPE due to potential shortages as part of preparations for a reasonable worst-case scenario as detailed in NHS England's Third Module 3 Statement.

259. Around this time, the Government started to secure additional PPE stock. Through joint work across the UK CNOs, I was able to agree with the CNO for Northern Ireland to receive 25,000 gowns from their stockpile under mutual aid arrangements to relieve the acute shortage, as Northern Ireland had greater availability at that point. These gowns were received on 18 April 2020 and I will be forever grateful to the then CNO for Northern Ireland for facilitating this.

260. As more Covid-19 positive patients were being treated in intensive care units and other settings where aerosol generating procedures were taking place, more staff were required to use FFP3 masks. The increased use of FFP3 masks by more NHS staff combined with supplies being required to meet this demand coming from a wider range of manufacturers led to reports concerning both improper safety procedures and FFP3 masks not fitting Black, Asian and minority ethnic staff.

261. NHS England's National Medical Director and I wrote to Trusts jointly on 24 April 2020 in response to reports of organisations only undertaking fit checking of new masks instead of fit testing, as is required under health and safety legislation. This issue required specific action. Fit testing is a legal requirement and must be carried out by a competent individual to ensure that specific masks are safe for the individual user before they can be used. Fit checking is typically undertaken by the user every time that they use an FFP3 mask for which they have already been fit tested – it is not a substitute for fit testing **[RM/065] [INQ000330850]**.

262. Building on the evidence provided by the CNO BME SAG on 10 June 2020 (see Paragraph 60 above), a project was launched in June 2020 led by the DCNO for Patient Safety and Innovation, which gathered evidence and data from over 5,000 participants across 35 Trusts from a range of backgrounds **[RM/142] [INQ000477789] [RM/143] [INQ000477790]**. This work provided the evidence base for a quality improvement programme, which worked with 11 Trusts to gather learning and embed best practice across all healthcare settings.

263. The learning from this work along with a fit-testing algorithm was published by NHS England on 29 October 2020 for use by healthcare organisations. This outlined the process for fit testing, which included ensuring that a range of masks were available, results were recorded, and re-testing was undertaken when masks or the wearer's circumstances changed **[RM/066] [INQ000330889] [RM/067] [INQ000330961]**.

264. I communicated this work to nursing and medical leaders via the fortnightly calls that I jointly led with the National Medical Director. My team also ensured that this work was shared with others involved in PPE purchasing decisions to ensure the appropriate range and variety of PPE was procured.

265. As the pandemic progressed, concerns over the availability of PPE reduced but concerns over the level of PPE required by staff when treating Covid-19 positive patients increased. This was usually the case as new and more transmissible variants emerged. However, alongside this I also received communications from groups of NHS professionals who advocated the removal of all mask wearing within healthcare settings.

266. Guidance for NHS staff should be based on evidence and expertise and to support this during the pandemic:

    a. In response to reports of increased use of FFP3 masks as the Alpha variant emerged in late 2020, the DCNO for Patient Safety and Innovation

commissioned a rapid evidence review from the UK IPC Cell into whether the IPC guidance on mask use should be updated. This review recommended no change to the guidance, a position endorsed by PHE/UKHSA.

b. When the Omicron variant emerged, the UK CNOs jointly commissioned an expert review of the UK IPC Guidance by the UK IPC Cell on 26 November 2021. UKHSA subsequently made the same request of the UK IPC Cell and a consensus position based on a review of the latest evidence was agreed by the Cell. This consensus was presented to the Senior Clinicians' Group by the Chair of the UK IPC Cell, the Deputy Medical Director of Public Health Wales, and was endorsed by all UK CMOs and CNOs, NHS England's National Medical Director and UKHSA (including UKHSA's Chief Executive Officer and Chief Medical Advisor). The document supported the existing position on FFP3 use in the UK IPC Guidance, noting that there is provision within the guidance for extended use of respiratory protective equipment following local risk assessment, but agreed to make this position clearer to staff by stating this at the start of the guidance **[RM/068] [INQ000421228]**.

267. Following the archiving of the UK IPC Guidance on 22 May 2022 and standing down of the UK IPC Cell following its final meeting in August 2022, NHS England IPC leads continued to work closely with UKHSA regarding FFP3 use and have continued to review the NIPCM on the basis of published evidence from UKHSA and other scientific bodies.

Nosocomial Covid-19 infections programme

268. Hospital acquired (or "nosocomial") Covid-19 infections were a major focus of NHS England's pandemic response. NHS England's nosocomial infections programme was focused on behaviours and activity within healthcare settings, supported by NHS England's IPC specialist team, NHS England's Medical directorate and regional Chief Nurses and Medical Directors.

269. As outlined in NHS England's Third Module 3 Statement, the Covid-19 Nosocomial Infections Programme consisted of a series of actions throughout the pandemic to support the effective and reliable application of the IPC measures recommended in the UK IPC Guidance. This included the development and publication of a range of supportive measures and tools for NHS organisations, with the aim of reducing the number of nosocomial infections.

270. The risk of in-hospital transmission of Covid-19 was considered from the very start of the pandemic. This risk began to materialise in late March 2020, when large numbers of hospitalisations occurred following widespread community transmission. Data produced by the Covid-19 Clinical Information Network ("**CO-CIN**") began to estimate that a proportion of confirmed Covid-19 cases were individuals who had acquired their infection during their hospital stay.

271. As noted in NHS England's Learning from Covid-19 report, the age and design of the NHS estate was a factor in nosocomial Covid-19 cases, as many NHS hospitals feature multiple bedded bays, which make it extremely difficult to isolate potentially infectious patients. This learning is being taken forward in the New Hospitals Programme, which is using a single bed room model as its basis for newly designed facilities.

272. Policy options for improved surveillance and testing were presented to SAGE on 31 March 2020 in a paper from NHS England's National Medical Director. I received a copy of this paper the day before its presentation to SAGE and shortly before it was discussed at a Senior Clinicians' Group meeting **[RM/069] [INQ000119727] [RM/070] [INQ000068750]**.

273. The scope for implementation of the recommendations in the paper (such as testing of asymptomatic healthcare workers and patients, serological testing of healthcare workers, environmental sampling and increased use of masks by all healthcare workers) was limited by constraints on testing, PPE and staff capacity, but demonstrated that the key scientific elements required to tackle in-hospital transmission were already being considered.

274. Responsibility for this work on nosocomial infections passed to me due to my executive responsibilities for IPC from 14 April 2020. Details of actions in this area are outlined in detail in NHS England's Third Module 3 Statement. Actions taken during Wave 1 are set out in Annex 4.

275. The key elements in tackling this issue in this early period were:

a. accessing accurate data to understand the scale of the challenge;

b. making Trusts aware of their own cases and outbreaks;

c. enabling NHS England to identify where multiple cases were emerging; and

d. creating the tools to both enable Trusts to tackle these issues and NHS England to support them in doing this.

276. Two other vital developments in tackling nosocomial infections that were developed as Wave 1 progressed were greater testing of patients admitted to hospital and inpatients and the introduction of universal mask wearing/face coverings in hospital settings.

277. In terms of testing, from a position of very limited availability in late March 2020, as Wave 1 progressed, DHSC delivered significant increases in testing capacity and capability, both for healthcare staff and patients and for the wider public.

278. This additional capacity supported patient testing on admission (from April 24 2020 onwards) and inpatient testing between days 5-7 of their hospital stay (from 15 May 2020 onwards). This supported healthcare staff to more rapidly identify and isolate Covid-19 positive inpatients and provided intelligence to the nosocomial data reporting. The additional testing capacity was significant in identifying and enabling targeted actions by Trusts to prevent onward transmission.

279. In terms of universal mask wearing for NHS staff and face coverings for visitors in healthcare settings, I supported this measure being introduced in advance of the announcement made by the SSHSC on 5 June 2020 and subsequent implementation from 15 June **[RM/071] [INQ000421244] [RM/072] [INQ000224391]**.

280. NHS England's Third Module 3 Statement outlines the detailed actions in relation to universal mask wearing. In April 2020, the official position on the wearing of facemasks by the general public had been that the evidence for their effectiveness in preventing the virus from spreading was weak; this was the position of a Deputy CMO on 3 April and reiterated by his fellow Deputy CMO on 23 April. However, as the month progressed, and there was a greater understanding of the risks of asymptomatic transmission, there were increasing calls for wider use of masks in a range of specific settings. In two webinars I led with NHS staff on 24 April (one with IPC specialists and another with DoNs and Medical Directors, jointly led by the National Medical Director) the issue of more widespread use of surgical facemasks in healthcare settings was repeatedly raised, particularly because further consideration was being given to the cohorting of Covid-19 and non-Covid-19 patients as plans for wider patient testing were being developed.

281. On 7 May 2020 I commissioned a gap analysis review by the UK IPC Cell of the UK IPC Guidance content in its entirety (see Paragraphs 242 to 243 above). On the issue

of mask wearing, the review recommended that "*[c]onsideration should be given to recommending the routine use of surgical masks by healthcare workers including in non-clinical areas*". I supported this recommendation and in a letter to the Director and Deputy Director of PHE's National Infection Service on 11 May, I requested that this and the other measures identified in the gap analysis be considered for inclusion in the UK IPC Guidance.

282. To further progress this recommendation, on 14 May 2020 I commissioned NHS England's NCD for IPC and Head of IPC to undertake a review of the evidence for nosocomial spread, covering universal mask wearing to reduce virus transmission. This work subsequently incorporated a separate specific request from PHE on 15 May 2020, following discussions at SAGE that week, for a review of evidence for wider mask use within healthcare settings. The NCD for IPC presented a paper on this for discussion at the HOCI WG on 21 May 2020. From this work, I felt that the weight of evidence for the introduction of universal masking for healthcare workers to prevent Covid-19 transmission in healthcare settings was compelling. However, as IPC requires a multidisciplinary response, it required consensus and approval from a wide range of senior clinical and scientific colleagues from across the UK **[RM/073] [INQ000395649]**.

283. While approvals were being sought, I recognised that the service would need time to prepare for change in this PPE recommendation. Therefore, between 19 and 22 May 2020, the NCD for IPC, the Head of IPC and the DCNO for Patient Safety and Innovation undertook seven webinar sessions (one in each NHS England region), attended by a total of over 500 Trust Directors of Infection Prevention and Control, DoNs, microbiologists and IPC lead nurses to discuss this recommendation. These engagement sessions were used to signal to key personnel that universal face mask usage and face coverings were being considered for all staff in all healthcare settings.

284. On 21 May 2020, I highlighted this potential change to NHS England's Chief Commercial Officer so that any facemask supply requirements could be factored into PPE procurement activity. On the same day, I also made a request to the UK IPC Cell to review the content of the UK IPC Guidance to include consideration of extended use and implementation of universal face masking.

285. I commissioned a paper based on the HOCI WG paper, which the NCD for IPC and I presented to NIRB on 27 May 2020. NIRB approved the proposals on the basis that these would be subject to further senior clinical discussion and approval from the appropriate organisations **[RM/074] [INQ000421226]**. Following feedback from NIRB

on 27 May, further discussion took place at the Senior Clinicians' Group on 28 May. This discussion saw a range of views on the issue expressed by senior clinical leaders. There was no consensus at this point among the UK CMOs for the introduction of this measure. As well as taking this paper to the Senior Clinicians' Group, the NCD for IPC and I also updated the Government's Chief Scientific Adviser on this work, firstly on 29 May 2020 via the NCD's attendance at a SAGE sub-group chairs meeting and then on 1 June when an evidence paper from the NCD for IPC and the chair of SAGE's Environmental Modelling Group, largely based on the paper presented to the HOCI WG on 21 May 2020, was shared for discussion.

286. On 3 June, I met with the SSHSC who strongly supported the introduction of universal face mask wearing in NHS settings and wanted this implemented as soon as possible **[RM/075] [INQ000421175]**.

287. On 4 June, SAGE endorsed the proposals for universal facemask wearing in healthcare settings in the evidence paper from the NCD for IPC and the chair of SAGE's Environmental Modelling Group and agreed to circulate the paper and their minutes to the relevant Government departments **[RM/076] [INQ000120526]**.

288. Following this endorsement, the SSHSC outlined that he wanted to announce the introduction of universal face mask wearing in NHS settings on 5 June 2020. I spoke to him on that day to advise on messaging for this announcement.

289. The SSHSC announced at the Government briefing on 5 June 2020 that face masks and coverings were to be worn by all NHS hospital staff and visitors from 15 June 2020.

290. The decision for this measure coming into force at a later date was due to a combination of factors including the time required to update the PHE/UKHSA's IPC guidance and prepare the NHS for implementation. It was agreed that this guidance would only apply to healthcare settings in England from 15 June 2020 **[RM/071] [INQ000421244] [RM/072] [INQ000224391]**.

291. Nosocomial infections were high profile throughout the Relevant Period and subject to scrutiny from Government. As well as the discussions with SSHSC on universal masking detailed above, I met with DHSC and the Cabinet Office to discuss this issue on a number of occasions. I also discussed this issue at the Senior Clinicians' Group on 16 April, 14 July and 24 September 2020, alongside the NCD for IPC.

292. Between the end of April 2020 and September 2020, I joined a number of Government meetings relating to infections in care homes. This included a Covid-Operations meeting on potential support for care homes from the NHS on 15 September 2020.

293. I met with the SSHSC on 11 June 2020 to discuss the data and actions in relation to organisations with higher than average numbers of nosocomial infections. I summarised the work being done to manage nosocomial infections, highlighting the letter and guidance provided on 9 June 2020, the work with Care Quality Commission and the recently announced face masks guidance for hospitals.

294. Further to this, my team worked with the Cabinet Office's Covid-19 Cross-Government planning team to provide assurance of actions to the Government, as nosocomial infections had been designated as a "Tier 1" priority by the Cabinet Office as part of this work. After a series of discussions over this period, by December 2020 the Cabinet Office were assured that our plan was sufficiently robust and agreed for the nosocomial workstream to report into them through the DHSC programme office via a short weekly progress update.

295. The summer of 2020 saw a reduction of nosocomial infections as community transmission reduced. At this point, the work done in establishing the regional intensive IPC support teams as well as the data collected from and provided by Trusts developed over the summer of 2020 and enabled individual organisations to review their action plans and seek support as required. However, as infections grew in the community during Wave 2, Trusts were beginning to see increases in nosocomial infections.

296. As outlined in NHS England's Third Module 3 Statement, my team undertook intensive work with Trusts to develop "*10 Key Actions for IPC (including Testing)*" to support all Trusts with the prevention and control of nosocomial infections **[RM/077] [INQ000330890]**. In my view the two most vital elements of these actions were:

    a. implementing a further PCR test for all admitted patients on day 3 of their hospital stay, which enabled more infectious patients to be identified and isolated to reduce the risk of onward transmission; and

    b. advice on not moving patients around the hospital unless clinically necessary, another key element in preventing virus transmission from patient to patient.

297. An early study presented to the HOCI WG in April 2020 found that 84% of nosocomial infections were patient to patient infections and that healthcare worker to patient infections accounted for only around 1% of nosocomial cases. Further work on this based on an analysis of four hospitals in Oxford up to October 2020, along with modelling at a national level up to July 2020, was presented to the HOCI WG on 17 December 2020. This further analysis supported the findings of the April 2020 work.

298. NHS England analysts presented a paper to the HOCI WG on 28 January 2021 analysing the potential drivers for increases and variations in nosocomial infection rates. This found that of the factors examined, the proportion of beds occupied by Covid-19 patients was the most important factor, with the prevalence of Covid-19 in hospitals being a direct result of high levels of transmission in the community **[RM/078] [INQ000235632]**.

299. As the combination of non-pharmaceutical infections and the rapidly developing vaccine programme reduced the number of community infections, nosocomial rates also decreased. To support this, the Every Action Counts suite of support tools was developed by NHS England's IPC team to embed consistent IPC practice within organisations. Through this period, regular updates were provided within NHS England through NIRB meetings and on to DHSC on the numbers of nosocomial infections.

300. In late 2021, my IPC leads supported all efforts to ensure that IPC measures were being applied using a risk based and proportionate approach in response to the increasing backlog of elective care. This included supporting Trusts to operationalise the UKHSA electives guidance published on 27 September 2021 and the revised version of the UK IPC Guidance published by UKHSA in November 2021.

301. As the Omicron variant became dominant in the UK in late 2021, the number of nosocomial cases rapidly increased. However, as it became evident that Omicron was leading to lower morbidity and mortality when compared with previous variants, UKHSA did not advise any changes to the UK IPC Guidance. UKHSA's guidance outlining reductions in public testing from April 2022 and NHS staff and patient testing from August 2022 confirmed that Covid-19 was now considered to be similar to other infectious respiratory diseases.

302. In terms of key learning at the start of the pandemic, our central team was relatively small and not all NHS England regions had an IPC lead in post. This situation rapidly changed in the first months of the pandemic, as further team members with IPC

expertise joined NHS England and provided a full support package to Trusts. This additional capacity helped with the implementation of the IPC Guidance and the creation of tools for Trusts to support their own assurance and monitoring processes.

303. Another key learning was the importance of clarity in relation to roles and responsibilities in respect of IPC guidance. Over the Relevant Period the work in this area was undertaken by PHE/UKHSA and the UK IPC Cell:

    a. From January to April 2020, PHE drafted and published the UK IPC Guidance, asking the UK IPC Cell for advice on specific areas.

    b. From mid 2020 onwards, as the guidance began to require greater operational IPC expertise, the UK IPC Cell took on a more prominent role in the drafting of IPC guidance.

304. In practical terms, the UK IPC Cell, once it had taken on a more prominent role in drafting the UK IPC Guidance from PHE in mid 2020, ensured that senior PHE/UKHSA views on draft guidance were sought and addressed to enable timely PHE/UKHSA publication approval, due to PHE/UKHSA's statutory responsibilities.

305. Going forward, clearer arrangements in terms of organisational roles and responsibilities on guidance production have been agreed between DHSC, NHS England and UKHSA. This includes collaboration on pathogen-specific guidance from UKHSA, which is reflected in the operational guidance contained within the NIPCM. A copy of this agreement will be provided to the Inquiry once available.

306. One of the key learnings from the pandemic is that multidisciplinary IPC expertise across both NHS England and all NHS organisations is a vital element of future pandemic preparedness.

307. An analysis published by PHE on 29 October 2021 showed that the application of recommended IPC measures is likely to have reduced healthcare worker infection rates by around 51% in Wave 1, with patient infections being a fifth of what they would have been in this period without these IPC measures, equating to an estimated 140,000 nosocomial infections being prevented. The analysis also noted that the single most helpful measure implemented over this period to prevent the spread of the virus between healthcare workers was the introduction of universal mask wearing in healthcare settings **[RM/079] [INQ000330923]**.

SECTION 5: MATERNITY

308. NHS England's Fourth Module 3 Statement provides a detailed account of the impact of the pandemic on antenatal care, maternity services, postpartum and neonatal care as well as an overview of pre-pandemic programmes.

309. This section will supplement NHS England's Fourth Module 3 Statement, focusing on my own actions and work as CNO in relation to maternity services during the pandemic.

310. Maternity services are an example of an NHS service continuing throughout the Relevant Period. Unlike many other services, demand was unchanged and therefore the service could not be stepped down. However, these services also faced challenges, including:

    a. staff absence due to illness and self-isolation. These challenges were compounded further due to the ongoing midwifery vacancies, which in December 2019 totalled 838;

    b. widespread concerns about the impact of Covid-19 on pregnant women and babies, as well as the same concerns shared throughout the NHS workforce relating to their own safety;

    c. the implementation of cohorting within maternity units;

    d. home birth services were reduced due to staff shortages as home births require one, sometimes two midwives to be present throughout and are therefore more resource intensive than maternity units; and

    e. the restrictions on partners or loved ones being present at antenatal and postnatal care, and in some instances, at births.

311. This situation changed over time through a number of developments. One of the major developments was a greater availability of testing, particularly as LFDs were more widely used, which not only allowed for visiting guidance to be refined and clarified to enable partners to access all parts of the woman's maternity journey (not just during labour), but also supported staff availability to deliver a full range of services.

312. Implementation of clinical guidance from RCOG and RCM, along with operational guidance and regional support from NHS England, also supported maternity

providers to safely restore services and enable a greater choice of birth settings as 2020 progressed.

313. However, there was not a uniform picture across all Trusts and for all individuals, as Trusts managed service delivery and partner access as appropriate to their own circumstances to support patient and staff safety.

314. In parallel to the pandemic response, maternity transformation and service improvement came under renewed focus following:

    a. the publication on 10 December 2020 of the Ockenden Review's first report into maternity services at Shrewsbury and Telford Hospital NHS Trust and the final report, published on 30 March 2022; and

    b. the report by Dr. Kirkup on maternity services in East Kent Hospitals NHS Foundation Trust, published on 19 October 2022.

315. These reviews and their responses led to a series of focused actions across all maternity services to deliver the national ambition for safer, more personalised, and more equitable maternity and neonatal care for women, babies, and families. This work was developed in the challenging context of the pandemic.

316. The continued work of maternity services throughout the pandemic is a testament to the work of all midwives, obstetricians, neonatologists, neonatal nurses, maternity support workers and their entire maternity and neonatal teams.

317. My maternity and midwifery team, led by then CMidO and NCD for Maternity, worked hard throughout this period and I am grateful for all that they did to support frontline services for women, their babies and their partners. I also want to extend my thanks to the Chief Executive of the RCM and the then President of RCOG, for their exceptional leadership and collaboration throughout this period.

Provision of maternity services

318. The delivery of maternity services was an enormous challenge for the NHS, particularly during Wave 1. Trusts were responsible for the delivery of these services but were reporting pressures from staff absence and the redeployment of specialist staff, particularly anaesthetists, but also midwives who were also registered nurses, to support the treatment of Covid-19 patients in intensive care units.

319. Following discussion of the staffing pressures faced by maternity services at a 'Two Steps Ahead' meeting on 20 March 2020, I received a note from the then CMidO and NCD for Maternity on 22 March outlining the risks to maternity services **[RM/080] [INQ000421159]**. This note covered risks to home birth services, stand-alone midwifery units and access to pain relief. The note outlined mitigating actions being taken through regional midwifery leads to manage these risks:

Table 1 Actual risk and areas of concern

Concern/risk	Risk	Mitigation	Follow up
1. **Risk** -Due to the current pressures experienced across urgent and emergency care services, LAS are no longer in a position to guarantee an ambulance response to women choosing to have a home birth, or birth in one of London's three stand-alone birth centres.	Should there be an obstetric emergency requiring transfer to hospital, there will be no ambulance service to respond. Midwives are legally obliged to attend the birth and in the absence of emergency support there is an immediate risk to the woman, fetus/baby and midwife.	LAS have been asked to discuss this decision with a view to: women who choose to 'free birth[1]', should there be an obstetric emergency, they will be have ambulance transfer to an obstetric unit Discuss plans with London's maternity providers so that: risks can be managed, women communicated to and staff prepared	Update will be available by the 24th March 2020
2. The South East coast ambulance service would like to discuss the decision made by LAS with the South East Coast Regional Chief Midwife 3. The ambulance service in the Midlands have expressed interest in this approach			
Concern 1. Potential withdrawal of epidurals for non-emergency situations is being explored by maternity services across England because the anaesthetist may need to prioritise Covid-19 patients	The choice of epidural for pain relief during labour may not available and therefore women's choice of pain relief will be limited.	Regional Chief Midwives to discuss this concern with Maternity providers and encourage the preparation of communication to women booked to receive maternity care in collaboration with their Maternity Voices Partnership	27th March 2020
Concern 1. Potential closure of Midwifery led units and Stand-Alone Birth Centres in England, further to Ingleside Birth Centre closing next week and other maternity providers considering this as a viable option for centralising maternity care. The overall aim relates to staffing challenges resulting from Covid-19	The choice of place of birth will limited	Regional Chief Midwives to discuss this potential risk with Maternity providers and encourage the preparation of communication to women booked to receive maternity care in collaboration with their Maternity Voices Partnership	27th March 2020

320. Faced with these pressures, Trusts had to make difficult decisions to ensure safety was prioritised. Many of these decisions involved temporarily restricting access to services which could not provide rapid access to obstetricians. These decisions were taken locally as NHS services do not need to consult with NHS England, or with me personally.

321. I was updated on the current status of maternity service provision by the then CMidO on 2 April 2020. This outlined the complete picture of changes to maternity services at that point across England. A large number of Trusts had chosen to close their home birthing services and others had closed freestanding midwifery units on safety grounds.

322. Throughout the Relevant Period a range of guidance was issued to support maternity services. Guidance was routinely published by RCOG and RCM following co-production with NHS England's maternity team. This partnership working between the Royal Colleges and the then CMidO and then NCD for Maternity ensured that the guidance was based on clinical requirements and evidence.

323. As the executive lead for maternity, on 6 April 2020 I signed off the "*Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic*", which was published on 9 April. This operational guide was jointly developed by the Royal Colleges and clinical leads in the maternity team. NHS England's maternity teams supported Trusts to maintain services in line with this guidance.

324. In addition to the 9 April guidance, NHS England took a number of actions to support the provision of maternity services:

a. capturing data on changes to maternity services in a weekly situation report ("**SitRep**") (first produced on 22 April 2020) created by the Maternity Team to gather information and enable coordinated support across local maternity systems;

b. including midwives within the BBS programme;

c. sharing a list of independent midwives with Trusts for them to access this additional resource as appropriate;

d. supporting the Royal Colleges to produce guidance (published 30 March 2020) to help Trusts and systems frame their decision-making around suspension of intrapartum care options. This guidance highlighted a number of conditions

which Trusts should satisfy themselves of before taking any decisions to temporarily suspend services **[RM/081] INQ000176666**.

325. The 9 April 2020 guidance was supported by the further publication of "*Delivering Midwifery intrapartum care where local COVID-19 escalation protocols are required to be enacted*" by NHS England on 20 July 2020. This document was developed collaboratively between NHS England, RCM and the NMC . It outlined the importance of maintaining one to one care for women and reaffirmed that midwives should not be redeployed to work outside of maternity services **[RM/082] [INQ000421169] [RM/083] [INQ000421179]**.

326. The reductions in infections through to the summer of 2020 enabled a wider range of maternity services to be restored. For example, in April 2020 57% of homebirth services were closed but by August this had dropped to 1%. Over the same period, there was a reduction in the numbers freestanding and alongside midwifery units being closed from 16 to 2.[12]

327. As Wave 2 continued to increase in late December 2020, discussions resumed with DHSC and professional regulators regarding the temporary registration of staff to support the response. As set out in Section 3, it was not considered appropriate for midwifery students to join the NMC's temporary register.

328. As Wave 2 continued to increase into January 2021, the RCOG and RCM wrote to NHS England's National Medical Director and I on 8 January 2021 seeking assurance that maternity services were not being affected by the internal redeployment of staff. On 14 January I confirmed that I had not received reports from Trusts of staff being redeployed as they were during Wave 1. Notwithstanding wider pressures being faced, the importance of maintaining safe maternity services was paramount.

329. I continued to receive weekly updates from my maternity team outlining service closures, restrictions on visiting and staff absence throughout 2021.

330. A significant impact on maternity services was felt in the summer and autumn of 2021 as the Delta variant became dominant. Staff absences due to sickness and self isolation led to a series of temporary closures of home birth services, freestanding and alongside midwifery units. There were also reports of four units experiencing

[12] There are two types of midwife-led unit - freestanding and alongside (alongside meaning that it is directly situated next to an obstetric service)

delays to or relocations for elective caesarean sections **[RM/084] [INQ000421197] [RM/085] [INQ000421198] [RM/086] [INQ000421199]**.

331. To support NHS maternity services to manage the impact of the pandemic in summer 2021, NHS England published its "*Maternity and neonatal services Action Plan*" on 10 August 2021. I presented this plan for approval by NIRB on 30 July 2021 **[RM/087] [INQ000421240]**.

332. The plan outlined 8 areas of focus and proposed actions at a local, regional and national level for each area to ensure the safe care of pregnant women who have tested positive for Covid-19. It also ensured the management of current pressures on maternity and neonatal services, including promoting Covid-19 vaccination for staff and pregnant women and looking across the NHS workforce and external organisations for flexible solutions to maintain services **[RM/051] [INQ000421229]**.

Concerns over pregnant women accessing maternity services

333. There were concerns through the Relevant Period that women might choose not to access NHS maternity services if they felt it increased their chances of themselves or their babies contracting Covid-19.

334. I first discussed this issue with the then CMidO on 2 April 2020, following reports from maternity providers. At my appearance at the No.10 press conference on 10 April, I raised this specifically and asked that any women with concerns regarding their pregnancy contact their midwife.

335. This issue was also discussed in a meeting with the then Parliamentary Under Secretary for Patient Safety and Mental Health on 24 April 2020, with action taken to communicate this message to pregnant women via local maternity systems.

336. From 27 April 2020, all pregnant women could access extra support via the NHS Volunteer Responder scheme, not just those who were shielding or vulnerable. This covered help with collecting shopping, medication and other essential supplies.

337. Concerns around access to maternity services were tackled more widely by the launch of the NHS Open for Business campaign, which aimed to inform a wide range of people, including pregnant women, that NHS services were available for their use if they needed them. Pregnant women were one of the main target audiences of this campaign, which was highlighted to maternity systems via our maternity bulletin of 27 April 2020.

338. The 'second phase' letter issued by NHS England on 29 April 2020 also advised Trusts to make direct and regular contact with all women receiving antenatal and postnatal care to explain how to access maternity services for scheduled and unscheduled care. The letter further emphasised the importance of sharing any concerns so that the maternity team could advise and reassure women of the best and safest place to receive care.

339. During Wave 1, evidence grew that the issue of reluctance to access maternity services was particularly an issue in Black, Asian and minority ethnic communities. Evidence from MBRRACE-UK[13] over the past decade shows that there is a higher risk of poor maternity outcomes for women from Black, Asian and minority ethnic groups when compared to white women, which is why this was always a priority within the Maternity Transformation Programme. Research undertaken in May 2020, funded by DHSC, showed that Black pregnant women were eight times more likely to be admitted to hospital with Covid-19 than white pregnant women.

340. The NIRB meeting of 19 June 2020 outlined the actions to be taken to support pregnant women from Black, Asian and minority ethnic groups. This package of measures was announced on 27 June and the then CMidO wrote to all Trusts, asking them to take four specific actions to minimise the additional risk of Covid-19 for Black, Asian and minority ethnic women and their babies **[RM/088] [INQ000280429]**:

a. Increasing support for at-risk pregnant women, for example by making sure clinicians have a lower threshold to review, admit and consider multidisciplinary escalation in women from a Black, Asian and minority ethnic background.

b. Reaching out and reassuring pregnant Black, Asian and minority ethnic women with tailored communications.

c. Ensuring hospitals discuss vitamins, supplements and nutrition in pregnancy with all women. Women with darker skin or those who always cover their skin when outside may be at particular risk of vitamin D insufficiency and should consider taking a daily supplement of vitamin D all year.

[13] MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership to run the national Maternal, Newborn and Infant clinical Outcome Review Programme which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

d. Ensuring all providers record on maternity information systems the ethnicity of every woman, as well as other risk factors to identify those most at risk of poor outcomes.

341. As outlined in NHS England's Fourth Module 3 Statement, polling completed for NHS England in September 2020 showed that amongst pregnant women, 74% agreed the NHS had put measures in place to limit the impact of Covid-19 for when they gave birth. However, the polling also showed that 22% would have hesitated before seeking help from their midwife due to Covid-19.

342. To offer further reassurance and support to pregnant women, the NHS's Help Us, Help You, public information campaign focused on encouraging pregnant women to attend routine antenatal appointments. This was following insight studies which suggested that some women, especially Black, Asian and minority ethnic women, were less likely to attend these due to concerns over Covid-19 transmission risk. This campaign ran from November 2020 until March 2021.

343. To support local maternity systems to improve communications with Black, Asian and minority ethnic women, the Maternity Team developed a toolkit in January 2021. This advised on strategies to support the delivery of the four specific actions announced on 27 June 2020, such as key messages, using a range of communications channels and working together with communities to create strategies and products **[RM/089] [INQ000421195]**.

344. This important work continued as the pandemic progressed and was further supported by the publication of "*Equity and Equality guidance for local maternity systems*" in September 2021, which outlined how the five key priorities identified in the 2021/22 NHS planning guidance to support improving equalities and reducing health inequalities could be delivered in maternity services **[RM/090] [INQ000421196]**.

Shielding and clinically extremely vulnerable definitions

345. DHSC was responsible for determining who should shield, and for issuing guidance on the precautions that people who identified as clinically extremely vulnerable ("**CEV**") were advised to take.

346. I was not involved in the decision to include pregnant women on the list of people at increased risk of severe illness from Covid-19, published on 16 March 2020. The issue of identifying individuals at high risk of complications/serious illness was

discussed at my first Senior Clinicians' Group on that same day. This discussion led to the inclusion of pregnant women with significant congenital heart disease to the high risk/CEV group, which was published on 18 March 2020.

347. My only contribution in this area was on 21 May 2020, where in the course of discussion on a proposed shielding risk stratification tool led by the Deputy CMO, I noted the importance of engaging with the trade unions if any changes were proposed. I am unaware of the nature and/or extent of any trade union engagement after this meeting as this work was not being led by NHS England.

348. In terms of the impact of this decision, I was aware of concerns that pregnant women were reluctant to attend planned appointments or seek help if problems arose with their pregnancy. I cannot say whether this was due to these decisions specifically or whether it reflected the wider public concern about the virus.

Access to maternity services for partners and visitors

349. Access for partners and visitors in maternity services was a particularly difficult and sensitive issue. NHS England's Fourth Module 3 Statement outlines the guidance issued on both wider visiting in hospitals and guidance which was specific to partners and visitors in maternity services.

350. I was kept informed of this work and supported publication, but relied on the specific clinical expertise of the then CMidO and NCD for Maternity and Women's Health to work with the Royal Colleges on an agreed position.

351. The wider visiting guidance, which was overseen by the Clinical Cell and issued in March and April 2020, was designed to be simple and clear to enable easy implementation by Trusts and to be understood by the public. All versions of the guidance published at this time included specific reference to permitting access to partners accompanying a woman in labour. I was not responsible for approving this guidance.

352. From the first week of April 2020, reports started to come to me, both directly and via the then CMidO and maternity team, of partners not being able to accompany pregnant women to their full range of appointments during their maternity journey. This was the case for scans in particular which are often undertaken in small rooms where maintaining social distancing was difficult. There were also cases of partners being unable to attend births or being unable to stay with their partners and babies in the period after the birth.

353. These decisions were for Trusts to make based on their own individual circumstances and I sympathise with all parents whose experience of birth was impacted by these decisions. I know that when making these decisions, staff were considering the safety of all mothers and babies, as well as their teams.

354. To understand the national picture of these concerns, the weekly maternity SitRep was expanded on 16 July 2020 to capture information relating to visiting restrictions from maternity providers. This data showed that a large proportion of providers were enforcing some form of restrictions to partners in antenatal and postnatal care. These restrictions mainly applied to antenatal scans (only 19% of units allowed partners to attend) whereas 97% of units were allowing partners to attend births, albeit that around half of these units only enabled this once active labour was confirmed.

355. The restrictions on partner access may have been a result of the national visiting guidance not taking into account the full range of activities on the maternity journey where a partner could offer their support. These restrictions on partner access were also occurring at a time when the restrictions placed on everyday activities were being eased, linked to the greater availability of testing and wider use of facemasks to help prevent the spread of Covid-19.

356. The maternity team led by the then CMidO and NCD for Maternity held discussions with stakeholders including the RCM and RCOG to explore how maternity visiting guidance could be revised to support greater access for partners. The then CMidO emailed me and NHS England's National Medical Director on 5 August 2020 outlining these discussions and asking for approval to co-produce maternity specific visiting guidance with the Royal Colleges. I agreed this proposal and it was discussed at NIRB on 17 August where support was given to produce and publish this guidance **[RM/091] [INQ000421230]**.

357. Guidance was published on 8 September 2020 by RCOG to support providers in reintroducing access for partners, visitors and other supporters of pregnant women whilst maintaining the safety of all service users, staff and visitors **[RM/092] [INQ000280496]**.

358. The majority of Trusts were able to implement this guidance over the autumn of 2020 but consistent implementation proved challenging as Covid-19 cases increased. To support Trusts, NHS England published: "*Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers*" on 14 December 2020. This outlined the important distinction between visitors to hospital

maternity services and partners, who should be able to support a pregnant woman at all times during her maternity journey. The actions document outlined a thorough risk assessment process should be undertaken to enable partner access **[RM/093] [INQ000330895]**.

359. Implementation of the December 2020 guidance was initially difficult as its publication came just as Wave 2 was increasing. Providers of maternity services had to balance the infection risk with the benefits of partners being present. This situation remained challenging due to high levels of community infection throughout 2021.

360. I appreciate that many maternity services had to make difficult decisions and that many women were not able to have the support they would have wanted during the pandemic, particularly when infections were high. As the risks to pregnant women from Covid-19 have reduced over time, Trusts have been able to return to pre-pandemic service delivery standards.

361. Executive responsibility for visiting guidance within the NHS was passed to me on 1 April 2022. However, by this point the service was once again at a point where local guidance was the primary source of information for Trusts.

SECTION 6: WIDER CLINICAL MATTERS

362. My role as an executive director of NHS England and my professional leadership of nursing and midwifery meant that I was involved in activity across a number of clinical areas where I was not executive lead.

Do Not Attempt Cardiopulmonary Resuscitation

363. Details of NHS England's actions in relation to Do Not Attempt Cardiopulmonary Resuscitation ("**DNACPR**") notices during the pandemic have been outlined in NHS England's Third Module 3 Statement. While I was not the lead for this area, I was involved in some activity in relation to this issue as outlined below.

364. Along with other colleagues, I had become aware of reports of inappropriate use of DNACPR notices in early April 2020. This issue was raised with me directly in a question from the media at the No.10 Coronavirus press briefing on 3 April 2020. I responded by outlining the clear position that DNACPR notices should only be put in place following sensitive discussions between patients and/or their families and clinicians to determine that this is the best option for the patient. I also noted that Covid-19 should not be used as a reason for not having these discussions.

365. Further to this, on 4 April 2020, I received one of my regular updates from the DCNO for Professional and System Leadership, which contained updates highlighting this issue from my Learning Disability and Mental Health Nursing leads. This update noted that these reports had been escalated to the Medical Director for Primary Care and that my leads were communicating the national position on DNACPR to their networks of Learning Disability and Mental Health nurses.

366. To reiterate the NHS England position on this issue, I co-signed a letter to NHS organisations dated 7 April 2020 along with NHS England's National Medical Director **[RM/094] [INQ000192705]**.

367. The issue was raised with me again via the QNI report The Experience of Care Home Staff During Covid -19, published in September 2020, which stated that 16 respondents (out of 163 QNI Care Home Nurse Network members surveyed for this report) had experienced 'blanket DNACPR notices' or examples of decisions being made without consultation with patients or families. I followed this up with the QNI, but due to the nature of the survey there were no specific details. The information about blanket DNACPR notices was shared with colleagues and fed into NHS England's wider action on this matter. I am grateful to the QNI for raising this issue in their report **[RM/095] [INQ000421184]**.

368. I was also amongst the senior clinicians who signed a letter dated 4 March 2021 which reiterated the NHS England position that it is unacceptable for people to have a DNACPR on their record just because they have a learning disability, autism or both **[RM/096] [INQ000339282]**.

Clinical frailty scale

369. This section sets out my involvement in the "Clinical Frailty Scale", which I understand to mean the rapid Covid-19 guideline on critical care published by the National Institute for Health and Care Excellence ("**NICE**") on 20 March 2020, which initially advised that all adults admitted to hospital, irrespective of Covid-19 status, should be assessed for frailty using the Clinical Frailty Scale.

370. A draft version of this guidance was shared with me, along with all members of the Senior Clinicians' Group, by the then Deputy Director of PHE's National Infection Service on 19 March 2020, during a meeting of the Group. I did not comment on this guidance due to other priorities and assurance that other experts were considering it.

371. Concerns about this particular guidance were raised directly with me by a Trustee of the Down's Syndrome Research Foundation UK on 23 March 2020, who was concerned that the application of this clinical assessment tool could have a disproportionate impact on people with a learning disability. I asked my lead for learning disability nursing to explore this with NICE and he subsequently confirmed to me and the Trustee that NICE had been made aware of these and similar concerns. NICE published revised guidance on 25 March 2020 which outlined that it should not be used to assess patients of any age with stable long-term disabilities, learning disabilities or autism.

SECTION 7: OTHER AREAS OF INVOLVEMENT

Private hospitals and Nightingale facilities

372. NHS England's Second Module 3 Statement outlines NHS England's role in the creation, commissioning, operation and decommissioning of the Nightingale Hospitals and Surge Hubs. I attended NIRB meetings where the planning and implementation of Nightingale facilities was discussed.

373. In terms of direct involvement, in mid-March 2020, I was, along with others from teamCNO including the HEE Chief Nurse, involved in the design of the workforce model for the London Nightingale facility. At the same time, NHS England's IPC team provided IPC specialist nurses to work in the London facility.

374. This work developed rapidly over 21 to 22 March 2020. On 23 March I was asked by NHS England's Chief Operating Officer and NHS England's Regional Director for London, to support the requirement for registered nurses to staff the 4,000 beds proposed for the London Nightingale facility. This level of staffing was not ultimately required as the London Nightingale facility treated far fewer patients than had been originally anticipated.

375. The London workforce model was adapted (as appropriate) for other Nightingale facilities, reflecting the slightly varied clinical model for each site. I supported the regional Chief Nurses and regional teams in the development of other Nightingale facilities. I attended the opening ceremony of the London facility, undertook a clinical mobilisation visit of the Harrogate facility and worked twice at the London site, all in April 2020.

376. Regarding private (independent sector) hospitals more generally, my direct involvement with this sector was to meet with lead nurses from these hospital

providers as part of my professional leadership role. For the period in question, there were several meetings where a range of Covid-19 related issues such as testing protocols and the rollout of the vaccination programme were discussed.

Elective care and diagnostic screening programmes

377. The Phase 1 Letter was first discussed at a meeting on 11 March 2020, which I did not attend. I was asked to review elements within a draft of this letter on 13 March. My team provided feedback on the section relating to clinical returners to make this less medically-focused. I was not personally involved in the decision making relating to postponing elective procedures.

378. I was aware that the idea of reducing elective procedures in the event of the impact of the pandemic being as predicted had been part of internal planning documentation from at least late February 2020 onwards **[RM/097] [INQ000421155] [RM/098] [INQ000421156]**.

379. However, as executive lead for Children and Young People, the impact of the pandemic on children and young people was something that concerned me. As health services stepped up to manage the wave of Covid-19 patients in March and April 2020, as per the Phase 1 Letter, other non-urgent services were paused to enable the NHS to have the best chance to manage the anticipated number of patients with Covid-19. This included elective and community services for children.

380. The pausing of children's community services caused concern as it meant some of the most vulnerable children (children with Special Educational Needs/looked after children) did not receive services and health visitors were not available to support new mothers or spot safeguarding concerns.

381. The unintended consequence of the redeployment of health visitors and children's community nurses during Wave 1 concerned me greatly. I discussed this with PHE's Chief Nurse and we agreed that we needed to signal the importance of these services to the health system and local authorities.

382. On 28 May 2020, I sent my nursing phase 2 response letter to regional Chief Nurses. This communication outlined that I had been working with PHE colleagues (and Local Government and the Association of Directors of Public Health) to advise these services to return to their commissioned service model **[RM/099] [INQ000421174]**.

383. This restoration of children's community services was confirmed by NHS England's publication of "*COVID-19 restoration of community health services for children and young people*" on 3 June 2020 **[RM/100] [INQ000421234]**.

384. Subsequent to this, the Institute of Health Visiting contacted me and the Chief Nurse for Public Health to inform us that some organisations were planning to once again redeploy health visitors to manage increasing Covid-19 cases. To protect these vital children's services, the Chief Nurse for Public Health and I issued a joint letter with the Local Government Association on 7 October 2020 making it clear that health visitors and school nurses should not be redeployed other than in exceptional individual circumstances, such as having critical care experience **[RM/101] [INQ000347184]**.

385. One other important issue during the pandemic which impacted on children was the large increase in respiratory syncytial virus ("**RSV**") in summer to autumn 2021. This virus is seasonal, usually appearing in winter and generally has mild symptoms, but can lead to serious illness in children under two years of age. On average, around 33,500 children in the UK require hospital treatment due to RSV each year.

386. Due to measures taken during 2020 by the Government to reduce social interaction, the number of RSV-related hospitalisations in winter 2020/21 was far lower than usual. NHS England's NCD for Children and Young People first raised the potential for a surge in cases as a risk in February 2021. Modelling from PHE/UKHSA in April, based on evidence from Australia and New Zealand, suggested that there would be a significant surge in RSV cases in 2021.

387. I wanted to ensure that the NHS was prepared to manage this. I worked with NHS England's NCD for Children and Young People and Specialised Commissioning colleagues to highlight this issue to the NHS England executive in April 2021. Work commenced on resilience plans for paediatric intensive care to manage a surge of RSV related illness, with regions asked to draw up plans.

388. On 23 July 2021, I updated NIRB on an increase in rates of RSV, particularly in the North West region, and on the preparatory actions in terms of planning, training as delivered by PHE and the moving of the NHS England RSV group into the current incident structure with the establishment of a Paediatric Cell.

389. To help to communicate the risks of RSV more widely and effectively, a webinar was set up by NHS England's Director of People and Communities on 30 July 2021. This involved both national and local children's charities, utilising the structure of the

VCSE Health and Wellbeing Alliance and other networks to reach a wide range of different charities. Charities were asked to share the information provided in the webinar with parents of children that might be at risk of RSV.

390. As cases increased through the late summer into autumn 2021, NHS services implemented their plans to respond to this surge. By the time the peak had passed, there had been twice as many cases as in a normal RSV season. However, NHS services were able to manage this through their resilience plans.

391. A lessons learned report on this was presented to OpReD on 8 June 2022, stating that the coordinated whole system approach enabled by senior leadership was important in managing this issue. The work done in 2021 helped to support local management of future RSV increases **[RM/102] [INQ000421236]**.

Technology

392. In terms of my role in the increased use of technology in healthcare settings, as this area is not part of my direct responsibilities, my contribution and that of my team was limited to highlighting and supporting the work of others. Actions included:

   a. using my appearance on the No.10 podium on 3 April 2020 to highlight the ability to use technology to support care when loved ones were restricted in being able to visit patients;

   b. providing professional leadership to the Chief Nursing Information Officer ("**CNIO**"), who was appointed by NHSx in May 2020 with my support. She worked on a range of activity to support nursing leadership in digital programmes. During the Relevant Period, the CNIO worked on supporting the rollout of digital technology to enable remote consultations and training packages for staff to support the increasing use of technology, reporting to the NHSx Chief Executive; and

   c. providing nursing professional input into the work led by the National Director for Primary and Community Care on the Oximetry@home programme, which provided technology to enable people with Covid-19 to monitor themselves at home (with appropriate clinical support) and reduce the need for hospital appointments and potential admissions.

Risk-based clinical pathways

393. I was not involved in (and have no direct role in) decisions relating to risk-based clinical pathways for ischaemic heart disease, colorectal cancer, hip replacement and Child and Adolescent Mental Health Services. These pathways are not part of my executive responsibilities.

394. I did, however, through my leadership of IPC for NHS England, support the establishment of a three risk-based clinical pathways which were developed by the UK IPC Cell and first introduced in the Covid-19 UK IPC Guidance published in August 2020. These were designed to reflect a patient's Covid-19 status (high, medium, and low risk also referred to as red/amber/green pathways) and played an indirect, but important role, in creating the conditions to enable the safe restoration of services for non-Covid-19 patients within Trusts, including for the specific conditions mentioned above. The design of clinical pathways for these services, based on these three risk-based Covid-19 pathways, was delivered by specialists within these services, supported by regional and national action as outlined in full in NHS England's Fourth Module 3 Statement.

End of Life

395. Members of the Nursing Directorate were seconded to work on the End of Life Care ("**EoLC**") Clinical Cell, under the leadership of the NCD for End of Life Care and the National Director for Primary Care, Community and Strategy, and supported them in this work. The EoLC Cell worked on visiting guidance as well as the clinical challenges in this area presented by Covid-19.

Safeguarding

396. NHS England's statutory responsibilities for safeguarding sit within my portfolio and work on this was maintained throughout the pandemic. The importance of this work in the context of social restrictions was emphasised to me through my attendance at the Government's 'Hidden Harms' summit on 21 May 2020, where I heard from charities and experts about some of the child welfare issues that were emerging which would in normal times be noticed at school.

397. I joined the safeguarding workshop as part of this summit and a range of issues were discussed, including the deployment of school nurses and health visitors to the frontline in the early response, services only being able to be delivered on line and the impact on young people's mental health, all of which had safeguarding

implications. This discussion helped to form my views on how we should protect these services in any second wave.

398. As well as the impact on children, I was also concerned about the increase in the number of domestic abuse cases being reported by charities in this sector. NHS England's Head of Safeguarding co-signed a letter with NHS England's Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres on 15 May 2020 highlighting the issue of domestic abuse to NHS staff and signposting to resources to help women in this situation. I was a signatory to a further letter in March 2021 urging women who had experienced domestic abuse and sexual assault to contact the NHS for support **[RM/103] [INQ000050547] [RM/104] [INQ000421232]**.

NHS Volunteer Responders Programme

399. The NHS Volunteer Responders Programme was coordinated by the Director for People and Communities. For this work, he reported to the National Director for Primary Care, Community Services and Strategy, due to the links between this work and the related community health and primary care responsibilities within their portfolio.

400. Although this work was not my responsibility during the pandemic, the Director for People and Communities kept me fully informed of work in this area via our regular one to ones and senior team meetings, which proved helpful in making links between this work and the wider work of the Nursing Directorate. I supported this work in media activity to highlight its success and thank volunteers for stepping forward **[RM/105] [INQ000106308]**.

401. Building on this work and following a commission from the Prime Minister's office, the Director for People and Communities and his team established the NHS Volunteering Taskforce in January 2022 to stimulate transformational change in volunteering and strengthen links between volunteer programmes in and outside the NHS in England.

402. I co-chaired the Taskforce with Sir Tom Hughes-Hallett and we made a number of recommendations to help take volunteering in health and care services to a new level. My team have taken this work on and so far we have:

    a. launched a £10m Volunteering for Health programme, designed to strengthen volunteering infrastructure and promote innovation;

    b. initiated a national data collection about NHS volunteers;

c. removed some unnecessary barriers (such as providing a full career history) to volunteering in the NHS; and

d. developed and tested a national portal for volunteering, to improve the volunteer experience and make it easier to match volunteers with roles.

SECTION 8: LESSONS LEARNED

403. The Nursing Directorate played a full role in NHS England's lessons learned exercises, including:

a. involvement in incident-wide lessons identified exercises;

b. contributing to the CMO's Technical report on the COVID-19 pandemic in the UK; and

c. providing content for NHS England's Covid-19 lessons learned report.

404. As well as these exercises, my teams underwent a process of continuous learning as the pandemic progressed, ensuring that learning was reflected through the Relevant Period. Examples of this include:

a. Ensuring staff health and wellbeing was a priority, building on learning from Wave 1, including the development of the PNA programme.

b. After Wave 1, advising the NHS that specific staff groups (such as health visitors and midwives) should not be redeployed away from their normal roles and that disruption to nursing student education should be avoided if possible.

c. Working on specific guidance to support maternity visiting arrangements for partners which recognised their unique status and distinguished them from visitors.

d. Using the experience of the pandemic to support a proactive approach to managing the increase in RSV in 2021, activating plans based on modelling, following this up with a lessons learned report.

405. I commissioned the Nursing 7 Point Plan Review following agreement at NIRB on 29 April 2020. The purpose of this work was to review the impact of the seven nursing workforce actions outlined in my letter of 6 April 2020. The review worked with a series of frontline staff and organisations to look at how the actions were delivered, the readiness of the nursing and midwifery professions for potential future waves of

Covid-19 and the challenges for nursing and midwifery in managing the restoration of services while Covid-19 was still prevalent.

406. The review made five interim recommendations in June 2020 before its final report and recommendations were published in November 2020. These were grouped under two themes: to support a future Covid-19 response; and to support future pandemic planning. The issues covered included clarifying communication to the system, internal accountability, assessments of the skills of nurses on the NMC register who were not working in the NHS and the development of a specific nursing workforce mobilisation plan as part of future pandemic planning **[RM/012] [INQ000421190]**.

407. My responses to both the interim recommendations and the final recommendations were published in December 2020. These responses acknowledged where we had already taken action to meet the recommendations and also outlined the plans in place to address outstanding recommendations. I want to thank the review's Chair, Dr Sarah Pinto-Duschinksy and its Vice-Chair, Dr Elaine Maxwell, for this valuable work **[RM/106] [INQ000421191] [RM/107] [INQ000421192]**.

408. One of the most important aspects of learning from the pandemic specific to nursing and midwifery was to capture experience and best practice from frontline staff. This work was brought together to form the "COVID-19 Catalogue of Change", which provides frontline staff with case studies taken from day-to-day nursing and midwifery practice as we adapted to working in different ways to continue to ensure high quality care during the pandemic **[RM/108] [INQ000421237]**.

Conclusion

409. The pandemic was a global health emergency; it is the greatest challenge that the NHS has ever faced. As well as the tragic deaths of many thousands of people, so many others across society are living with its impact today.

410. I want to once again pay tribute to our NHS staff for the incredible effort they put in to the country's response to the pandemic. Many of my colleagues tragically died during the pandemic and many more others continue to feel its impact today. In terms of my own professions, every nurse, nursing associate, midwife, volunteer and HCSW should be enormously proud of the care they provided for our patients and each other.

411. To prepare the NHS for any future pandemic, we need to ensure that we have enough staff, facilities and the technology to be able to respond effectively and that

our staff have the right support in place to ensure that they can meet these most challenging situations. The heart of the NHS is the people who work in it and its future depends on our continued investment and support in our workforce.

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**

Dated: 17 May 2024

ANNEX 1

Career History

1. The key roles which I have held since 2007 are set out in the table below. Prior to these roles I held various positions within the NHS.

Date	Role
Since January 2019	Chief Nursing Officer for England.
April 2016 to January 2019	Executive Director of Nursing, Deputy Chief Nursing Officer for England, and the National Director of Infection Prevention and Control at NHS Improvement.
July 2015 to April 2016	Nurse Director at Monitor (the independent regulator of NHS Foundation Trusts).
October 2011 to July 2015	Regional Chief Nurse and Nurse Director of NHS England's Midlands and East Region.
July 2009 to September 2011	Regional Chief Nurse and Nurse Director of the Midlands and East NHS Strategic Health Authority.
September 2007 to June 2009	Chief Executive Officer of Mid Essex Hospitals NHS Trust.
October 2005 to September 2007	Chief Executive Officer of The Queen Elizabeth Hospital King's Lynn NHS Trust.

2. During my career, I have also obtained several relevant qualifications whilst working, including a postgraduate diploma in management studies and an MBA in hospital management.

ANNEX 2

Nursing Directorate

Nursing Directorate current structure

Nursing directorate

Director of Maternity and CYP Phoebe Robinson (reporting to Duncan Burton)
- Children and Young People
- Maternity Transformation Programme

DCNO for Professional & System Leadership Acosia Nyanin
- Safeguarding
- Nursing Professional Development
- Professional & Clinical System Leadership
  - Community & Primary Care
  - Mental Health
  - Learning disabilities
  - UEC
- Leadership and Strategy Development Professional Practice (incl BME nursing)
- Nursing Research, Strategy development & Genomics

DCNO for Quality, Sustainability & Innovation Charlotte McArdle
- Quality Strategy, Leadership and Governance
- Service Delivery Transformation and Resilience
- Women's Health and Wellbeing
- Patient Safety and Improvement
- Sustainability and Innovation

DCNO for Policy & Strategy Mark Radford
- Policy and Strategy
- Professional strategy and regulation

Chief Midwifery Officer Kate Brintworth
- Maternity Safety & Quality Improvement
- Leadership & Professional Matters
- Midwifery Research

DCNO for Clinical Delivery Duncan Burton
- Infection Prevention and Control
- Children and Young People
- Nursing Workforce policy
- Maternity & Neonatal

Director for People and Communities – Neil Churchill
- Insight and Voice
- Experience and Partnerships (inc. Volunteering)
- Equalities and Involvement (inc LGBT Health)

Nursing Directorate 1 April 2020

Nursing directorate

- **Director of Quality and Operations (joint post with Medical) Lauren Hughes**
  - Children and Young People
  - Maternity Transformation Programme
- **DCNO for Professional & System Leadership Hilary Garratt**
  - Safeguarding
  - BME and Equalities Nursing
  - Professional & Clinical System Leadership
    - Community & Primary Care
    - Mental Health
    - Learning disabilities
    - CYP Nursing
  - Nursing Development Programmes
  - Continuing Healthcare
- **DCNO for Patient Safety & Innovation Sue Tranka**
  - Clinical Quality Governance
  - Infection Prevention and Control
  - Nursing-led clinical improvement
  - Patient Safety
- **DCNO for Policy & System Transformation Susan Aitkenhead**
  - Nursing Policy and Strategy
  - Collective leadership
  - Nursing Research
- **Chief Midwifery Officer Jacqueline Dunkley-Bent**
  - Maternity Safety Support Programme
  - Leadership & Professional Matters
  - Midwifery Talent Programme
- **DCNO for International Nurse Delivery and Nursing Workforce Duncan Burton**
  - International Nurse Recruitment
  - Nursing Workforce Improvement
- **Director for People and Communities – Neil Churchill**
  - Public and Patient Participation
  - Experience and Partnerships (inc. Volunteering)
  - Equalities and Involvement (inc LGBT Health)
  - Carers Programme

Notes:

- Jacqueline Dunkley-Bent in post until 14 May 2023, succeeded as Chief Midwifery Officer by Kate Brintworth.
- Sue Tranka in post until 31 August 2021, succeeded by Charlotte McArdle on 1 November 2021. Responsibility for IPC transferred to Duncan Burton on 1 September 2021.

- Susan Aitkenhead in post until 31 December 2020. Post reconfigured with responsibilities shared across DCNO portfolios.
- Mark Radford was Chief Nurse at Health Education England until April 2023. Current role in NHS England Nursing Directorate is 0.25WTE.
- Hilary Garratt in post until 25 June 2023, succeeded by Acosia Nyanin. Responsibility for NHS Continuing Healthcare transferred to Primary and Community Health Directorate on 1 April 2022.
- Matthew Jolly was National Clinical Director (NCD) for Maternity and Women's Health for the entire Relevant Period (succeeded in this role by Donald Peebles in February 2024). Mark Wilcox was NCD for Infection Prevention and Control from November 2020; prior to this he was Medical Advisor for IPC and Microbiology. Both of these NCD roles report to the CNO on a day to day basis but line management responsibilities, as with all NCDs, is with NHS England's National Medical Director.
- Deborah Sturdy was Strategic Advisor for Care Home Nursing within the CNO team from February 2020 until her appointment as DHSC Chief Nurse for Social Care in December 2020. In this role, she has a dotted line professional relationship with the CNO, but reports to DHSC's Director General of Adult Social Care.

ANNEX 3

CNO meetings involving stakeholders during the Relevant Period

Month	NMC	RCN	RCM	CNO System Call	QNI	UK CNOs	UK CNO Forum	CNO SAG	DoNs/MD Webinars	Unison	Unite
Mar 2020	21	21	5	4		12		2	1	3	3
Apr 2020	9	14	1	7		7		1	8		
May 2020	4	6	2	8	1	7		2	4		
Jun 2020	2	6		8		4		2	3		
Jul 2020	4	5		6	1	2		2	2		
Aug 2020	3	1		8		1		1	1		
Sep 2020	1	1	1	7	1		1	2	6		
Oct 2020	1	2	1	9	1	1	2	2	1		
Nov 2020	4	7		8	1	2	2	2	3		
Dec 2020	7	3	3	9	1	1	2	4	1	1	
Jan 2021	6	5	2	8	1	2	2	1	4		
Feb 2021	1	2		5		1	2	1			
Mar 2021	1	2	1	4	1	1	2	3	1		
Apr 2021	2	3		2	1	2	2	3	2		
May 2021	3	2	2	2	1		1	2		1	
Jun 2021	5	2	1		1		2	2	1	1	
Jul 2021	3	2		2	3	2	3	1	2		
Aug 2021	7	1	2	1	3	1	3	1			
Sep 2021	3	0	2	1	2	3	2	2			
Oct 2021	1	2	2		2	3	2	1	1		
Nov 2021	4	2			1		1	2	3	2	
Dec 2021	3	3	2	4	1	3	5	3	2	1	
Jan 2022	4	3	3	4	2	5	4	2	3		

Feb 2022	4	1	1	2		1	2	1	4		
Mar 2022	3	3	1	1	1	2	2	1	2		
Apr 2022	3	1		1	1		2	2	1		
May 2022	0	0					2				
Jun 2022	2	3		2		1	2	1	1	1	1
Total	**111**	**103**	**32**	**113**	**27**	**64**	**48**	**49**	**57**	**10**	**4**

ANNEX 4

Nosocomial infections actions April to June 2020[14]

Date	Action
3 April 2020	Establishment of Hospital Onset COVID (HOCI) Working Group, co-chaired by me (from mid-April when I was invited to join) and Director of the National Infection Service (PHE) until 15 May, who was then replaced by NHS England's Medical Advisor for IPC and Microbiology (who from November 2020 onwards was NCD for IPC).
8 April 2020	Survey of IPC practices in Trusts.
24 April 2020	• Joint letter with NHS England's National Medical Director outlining that all non-elective admissions (including asymptomatic patients) should be tested for Covid-19, as testing capacity had sufficiently increased to allow for this to happen **[RM/109] [INQ000384649]**. • Webinars with Directors of Nursing, Medical Directors and provider IPC leads on actions needed to tackle nosocomial infections.
28 April 2020	Publication of a new IPC checklist for Trusts together with a compendium of documents and training resources **[RM/110] [INQ000421223]**.
28 April 2020	Letter from me to the Chair of NERVTAG and DCMO outlining the actions being taken following the NERVTAG Covid-19 Clinical Information Network data (the "**CO-CIN dataset**") on nosocomial infections **[RM/111] [INQ000068984]**.
5 May 2020	CO-CIN data on nosocomial infections sent to regional teams to enable support for Trusts.
22 May 2020	First HOCI data collection established as part of COVID SitRep to capture nosocomial data from all Trusts.
5 June 2020	HOCI data collection moves to daily collection to allow for real time data to be reviewed and actions planned.
5 June 2020	Regular IPC meetings with the DCNO for Patient Safety and Innovation and NHS England IPC team to discuss issues and actions move to daily frequency.
9 June 2020	I signed a joint letter with NHS England's Chief Operating Officer and National Medical Director to NHS organisations regarding minimising nosocomial infections in the NHS. This letter included advice on outbreak management and a recommendation for all staff and patients (as tolerated according to their clinical care

[14] Further actions relating to nosocomial infections from July 2020 onwards are detailed in Section 4 above.

	needs) to wear a face mask in all NHS settings **[RM/047] [INQ000088724]**.
18 June 2020	Daily HOCI data was included in the operations dashboard, allowing Trusts to review their own data and take action to tackle nosocomial infections.
19 June 2020	Agreement from the NHS England Executive Team for £3 million funding to establish national and regional IPC intensive support teams, to enable focused support on organisations with high nosocomial rates.
24 June 2020	I signed a joint letter with NHS England executives to NHS organisations outlining the need to take even greater steps to stop the spread of Covid-19 in healthcare settings in the light of further evidence of asymptomatic transmission, including setting out what inpatient testing should be carried out, what staff testing should be carried out, the requirement for the provider to undertake a root cause analysis of each nosocomial infection, what staff risk assessments should be conducted and how cases and outbreaks should be managed **[RM/048] [INQ000145891]**.