Witness Name: Jean White, Gareth Howells and Sumeshni Tranka

Statement No.: M3/CNOW/01

Exhibits: 213

Dated: 2 May 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF

JEAN WHITE, GARETH HOWELLS and SUMESHNI TRANKA

We, Jean White, Gareth Howells and Sumeshni Tranka, will say as follows: -

Preface

Jean White, Gareth Howells and Sue Tranka

1. This statement covers the period of time between 1 March 2020 and 28 June 2022 ("the relevant period"). During the relevant period three different individuals held the position of Chief Nursing Officer in Wales ("CNO").

    a. Jean White: 29/10/2010 – 06/04/2021

    b. Gareth Howells (Interim CNO): 07/04/2021-30/08/2021

    c. Sumeshni ("Sue") Tranka: 30/08/2021-present

2. In response to the Inquiry's Rule 9 request (M3-CNO-01), the Inquiry has requested a single witness statement, signed by all three individuals, capturing the responsibilities and actions of the CNO during the entirety of the relevant period.

3. Although provided in a single witness statement, each CNO is only able to speak to their own tenure in the role. To ensure clarity as to which part of the statement is attributable to which CNO, headers are used throughout with the name of the relevant individual or individuals.

4. Where matters set out are of a general nature applicable to the understanding and experience of all three CNOs during the relevant period, passages have been headed with the names of all three and may be read as an agreed position for all three CNOs during the relevant period. That said, each individual remains able to speak only to the position during their respective tenure.

5. The matters addressed within the statement relate primarily to matters that occurred within the relevant period, unless otherwise specified. Where the topics identified below refer to the work of the CNO during the pandemic, these references should be read as including any relevant work undertaken by Nursing Officers and/or the Nursing Directorate.

Role of the Chief Nursing Officer for Wales

Jean White, Gareth Howells and Sue Tranka

6. The role of the Chief Nursing Officer for Wales ("CNO(W)") is a director level appointment in the Senior Civil Service. It also includes the title of Nurse Director of NHS Wales. This title reflected the fact that Welsh Ministers and the civil servants who supported them had direct oversight of NHS Wales. Similarly, other civil servant directors in the Welsh Government held NHS facing role titles, e.g., the Director General of the Health and Social Services Group ("the Director General, HSS"), Dr Andrew Goodall CBE was also the Chief Executive Officer of NHS Wales, and the Chief Medical Officer for Wales ("CMO(W)"), Sir Frank Atherton was also the Medical Director of NHS Wales.

Professional background, experience and tenure of office

Jean White

7. I was appointed to the role of CNO(W) on 29 October 2010 and held this position until I retired from the Civil Service on 6 April 2021. My part of this statement addresses events that occurred, and decisions that were taken, during my time as CNO(W) until 6 April 2021. I was a permanent, full time civil servant within the Welsh Government.

8. I am professionally qualified as a registered nurse (adult) and as a registered nurse teacher with the Nursing and Midwifery Council ("NMC"), though following my retirement I am no longer on the professional register. I completed my state registered nurse training in Swansea in 1982, then worked for six years as a clinical nurse in operating theatre departments in South Wales and London. During this time, I completed a one-year full time post registration course in operating department nursing, and a Higher Education Diploma in Nursing.

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

10. In September 2000, I moved to the Welsh National Board for Nursing, Midwifery and Health Visiting. This body was part of the UK regulatory system for nurses, midwives and health visitors and was responsible for ensuring the standards of nurse and

midwife education and training in Welsh higher education institutions. I was initially a professional nurse advisor but became the Director of Quality and Standards.

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

12. The Welsh National Board for Nursing, Midwifery and Health Visiting closed in March 2002 and was replaced by the current UK regulator, the Nursing and Midwifery Council (NMC). I moved then to the new non-departmental public body, Health Professions Wales, which quality assured nursing and midwifery education in Wales on behalf of the NMC and undertook workforce development programmes for healthcare professionals in NHS Wales. While there, I began a part time PhD study in the School of Social Science, Cardiff University in October 2002.

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

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

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

Gareth Howells

16. I joined the NHS in 1981, on a youth training scheme. I subsequently completed my orthopaedic nurse training and registered general nurse training and began my career as a registered nurse in 1987. I hold the following qualifications: Diploma of Nursing Studies (including WNB 998: Teaching and Assessing, and WNB 264: Burns and Plastic Surgery Nursing Certificate), Orthopaedic Nursing Certificate, BSc (Hons) Nursing Studies, and MA Healthcare Law and Ethics.

17. I initially worked on general surgery as a staff nurse and later became a charge nurse, first in burns and plastic surgery and subsequently in trauma, and orthopaedics. I subsequently became a senior nurse manager in neurosciences and rehabilitation. I was part of the team that established NHS Direct in Wales in June 2000, and in September 2004 I was appointed to the role of Divisional Director of Nursing for Medicine, Elderly Care, Emergency Care and Community Services at Swansea NHS Trust.

18. In 2008, I took up my first role in NHS England as the Assistant Director of Nursing at the Royal United Hospital NHS Trust in Bath. Over the following 10 years I worked in various executive nurse and chief nurse roles in North Bristol NHS Trust, Somerset Partnership NHS Foundation Trust, Birmingham and Solihull Clinical Commissioning Group, and Birmingham Community NHS Foundation Trust.

19. In 2018, I returned to Wales as the Director of Nursing and Patient Experience at Abertawe Bro Morgannwg University Health Board which, following a service redesign in April 2019, became Swansea Bay University Health Board ("Swansea

Bay UHB"). Swansea Bay UHB is responsible for planning and delivering NHS services to a population of around 390,000 people in the Neath Port Talbot and Swansea areas. It commissions primary care services from GPs, opticians, pharmacists, and dentists across the area, provides mental health and learning disability services in both hospital and community settings, manages three major hospitals, a community hospital and primary care resources centres, and is responsible for the Welsh Centre for Burns and Plastic Surgery at Morriston Hospital (which provides specialist services to patients across south and mid Wales, and the southwest of England).

20. On 7 September 2020, I retired from the NHS and took up the role of Nursing Officer at the Welsh Government.

21. On 6 April 2021, the then Chief Nursing Officer for Wales ("CNO(W)"), Professor Jean White, retired and I was appointed to the role of Interim Chief Nursing Officer for Wales. I performed the duties of the CNO(W) on an interim basis, in addition to my duties as Nursing Officer. On 30 August 2021, Sue Tranka took up the post of Chief Nursing Officer for Wales and I reverted to my substantive role of Nursing Officer. In September 2021 I left the Welsh Government and returned to Swansea Bay UHB as their Executive Director of Nursing and Patient Experience.

22. My part of this statement addresses events that occurred and decisions that were taken during my time as Interim CNO(W) between 6 April 2021 and 30 August 2021.

Sue Tranka

23. I have worked in the Welsh Government since 30 August 2021. I have been in post since that date as the Chief Nursing Officer for Wales and Nurse Director, NHS Wales.

24. My professional background is that of a registered nurse. I started my nurse training in 1992, qualified as an enrolled nurse in 1994 and then worked, trained, and qualified as a registered nurse in Johannesburg, South Africa in 1998. I am in receipt of a Diploma in General Nursing, Diploma in Midwifery, Diploma in Mental Health

Nursing, and Diploma in Community Nursing from South Africa. I have been awarded a Post-Graduate Diploma, Healthcare Practitioner award from St George's Medical School, the University of London and I have a Master of Science in Clinical Quality Improvement from Middlesex University, London.

25. I joined the NHS on 7 April 1999, and have had continuous service in the NHS ever since. In total I have 25 years of NHS experience, having worked mainly in surgery and critical care. I have been an advanced nurse practitioner, and a nurse consultant working autonomously with a prescribing qualification whilst in clinical practice.

26. I am a Fellow of the Queen's Nursing Institute since 2021. The Queen's Nursing Institute is a registered charity dedicated to improving the nursing care of people in their own homes and communities. It is a national network of Queen's Nurses who are committed to the highest standards of care. The Institute helps nurses to develop their skills through training programmes, and to implement their own ideas for improving patient care. It also publishes research into nursing practice, workforce and education and improving knowledge and standards, and seeks to influence government, policymakers and employers to secure investment in high quality services.

27. I have been an Alumna Leadership Scholar of the Florence Nightingale Foundation since 2021. The Florence Nightingale Foundation's principal focus is to improve health, clinical outcomes and patient experience by building nursing and midwifery leadership capacity and capability, through enabling nurses and midwives to access sophisticated and bespoke leadership development opportunities, in the UK and overseas, which are tailored to individuals' needs, empowering them to use their professional voice.

28. In addition to my role as Chief Nursing Officer for Wales, I also hold an Honorary Professorship with Cardiff University, supporting both undergraduate and post graduate nurses with education in leadership. I was appointed to this role on 1 March 2022 for a five-year period. Prior to that, I held an Honorary Professorship at the University of Surrey from 2017 to 2021. I am a graduate of the Harvard Business

School for Government, where I completed a programme on Leadership for the 21st Century in 2022. I was appointed as a Trustee in August 2022 to the Board of the Florence Nightingale Foundation charity.

29. In January 2024, I took up an honorary position to the Board of the Centre for Research Equity through pharmacy, communities and healthcare at the University of Oxford. The Centre for Research Equity (CFRE), was established in October 2022 and launched in May 2023. It is an independent, collaborative health and care research centre intended to improve the lives of the population. The aim is to increase research equity through a unique collaboration that spans boundaries, to share knowledge, expertise, and resources to increase research equity and therefore health disparities in the population.

30. I have recently published two papers, on the value of improving patient safety and the health economics impact, and PPE fit testing effectiveness (which was written during the pandemic as a result of work I led):

    a. Value of improving patient safety: health economic considerations for rapid response systems–a rapid review of the literature and expert round table, by Christian Subbe, Dyfrig A Hughes, Sally Lewis, Emily A Holmes, Cor Kalkman, Ralph So, Sumeshni Tranka, and John Welch.

    b. Retrospective evaluation of factors affecting successful fit testing of respiratory protective equipment during the early phase of Covid-19, by Silvia Caggiari, Dan Bader, Zoe Packman, Jane Robinson, Sumeshni Tranka, Dankmar Bhning, and Peter Worsley.

31. Prior to joining the Welsh Government, from 3 January 2020 to 29 August 2021, I held the role of Deputy Chief Nursing Officer for England at NHS England and Improvement (which formally merged to form one NHS England on 1 July 2022). I reported directly to the Chief Nursing Officer for England, Dame Ruth May.

Role, function and responsibilities of the CNO

Jean White, Gareth Howells and Sue Tranka

32. The role of Chief Nursing Officer for Wales and Nurse Director, NHS Wales entails setting the professional agenda and future direction for the nursing and midwifery professions in Wales and acting as a senior adviser to the Welsh Ministers on all matters relating to nursing and midwifery practice and education. This includes providing leadership, advice, guidance, and support for delivery of the Welsh Ministers' priorities for nursing and midwifery in Wales, including through: -

    a. delivery of A Healthier Wales, the Welsh Government's 10-year strategy for health and social care.

    b. delivery and extension of the Nurse Staffing Levels (Wales) Act 2016.

    c. implementation of the Vision for Maternity Services (2019).

    d. delivery of the National Breast-Feeding Action Plan (2019).

    e. support and advise in respect of the Whole School Policy Agenda and community children's nursing services.

    f. improving the health of those with learning disabilities – reducing inequality in health outcomes.

    g. monitoring and overseeing the safeguarding work programme.

    h. promoting high quality, safe, compassionate care through the review of key frameworks and standards.

    i. increasing diversity in the nursing and midwifery workforce.

    j. establishing and maintaining effective communication networks across the NHS and independent healthcare sector.

k. providing an effective UK contribution to nursing, midwifery and healthcare policy in an international arena; and

l. working collaboratively to plan, design, extend, and enhance nursing and midwifery roles to improve clinical practice and integrated care across NHS Wales.

33. The CNO(W) is the head of the nursing and midwifery professions in Wales (circa 40,000 practitioners) and, as such, sets the professional agenda and future direction for these professions. The role is as the senior adviser to the Welsh Government on professional matters relating to the nursing and midwifery professions.

34. The CNO(W) is responsible for the professional performance and development of the executive nurse directors in the seven local health boards, three NHS trusts, and the Welsh Health Specialist Services Committee in NHS Wales ("the Nurse Directors"). This is a significant professional role in the Welsh Government's oversight of NHS Wales's delivery and performance, and the CNO(W) participates in performance review meetings with NHS Wales organisations led by the Director General, HSS.

35. The CNO(W) is managed by, and reports directly to the Director General of the Department of Health and Social Services and directly advises the Minister for Health and Social Services and the Deputy Minister for Social Services on matters related to the portfolio of responsibility described above.

36. The CNO(W) supports the implementation of the First Minister's priorities and those of his ministerial team, delivery of NHS services generally, and provides advice, briefings, and professional evidence to policy officers, ministers, Members of the Senedd, and Members of Parliament.

37. The CNO(W) is responsible for promoting high quality and safe, compassionate care in Wales and works closely with the Office of the Chief Medical Officer for Wales ("OCMO(W)") to progress the Welsh Government's quality, safety, and patient experience agenda, and with Healthcare Inspectorate Wales and Care Inspectorate

Wales to support their regulatory priorities. The CNO(W) also plays a central role in reviewing the health and care standards, developing a system for implementing an NHS duty of candour in Wales in readiness for the duty contained within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 coming into force.

38. The CNO(W) provides clinical and professional advice and support to the Welsh Government's NHS Quality and Delivery Group, and to the Welsh Government's regular performance and delivery focused meetings with NHS trusts and local health boards. This includes professional advice and support in all aspects of safeguarding, supporting the delivery of the key areas of work identified in the NHS Wales Safeguarding Network Plan, and working with Macmillan UK to progress the National Cancer Survey.

39. The Office of the Chief Nursing Officer ("OCNO(W)") also has policy responsibilities in relation to maternity and breast-feeding services, and quality and safety of care in NHS Wales (in tandem with the Chief Medical Officer for Wales). The officials within the OCNO(W) work with other directorates within the Health and Social Services Group ("HSSG") in the Welsh Government to provide expert professional advice to support delivery of the Welsh Government's priorities.

The Nursing Directorate

Jean White, Gareth Howells and Sue Tranka

40. The Nursing Directorate is part of the Welsh Government's Health and Social Services Group ("HSSG"). The HSSG is responsible for exercising strategic leadership and management of the NHS in Wales and is accountable for the robust stewardship of NHS funds. The HSSG exercises its leadership function through seven Local Health Boards, three NHS Trusts and two Special Health Authorities, all of which are directly accountable to the Minister for Health and Social Services through the Director General Health and Social Services (who is also the Chief Executive of NHS Wales). The Group is also the link between the local authorities'

social services directors and the Minister for Health and Social Services. The Group has the following overarching responsibilities:

a. promoting, protecting and improving the health and well-being of everyone in Wales.

b. leading efforts to reduce inequalities in health.

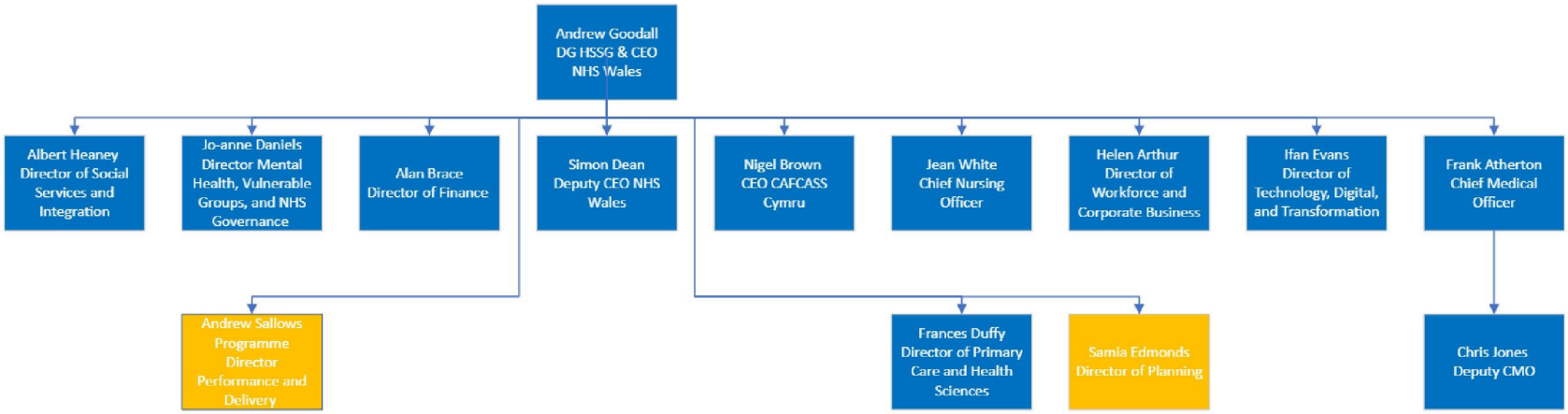
c. making available a comprehensive, safe, effective and sustainable National Health Service.

d. ensuring that high quality social services are available and increasingly joined up with health care and other services; and

e. ensuring that through Cafcass Cymru, children are put first in family proceedings, their voices are heard, and decisions made about them by courts are in their best interests.

41. We also produce here structure charts showing the Nursing Directorate's place in the wider HSSG Executive Director Team in January 2020, January 2021, January 2022 and February 2023, respectively.

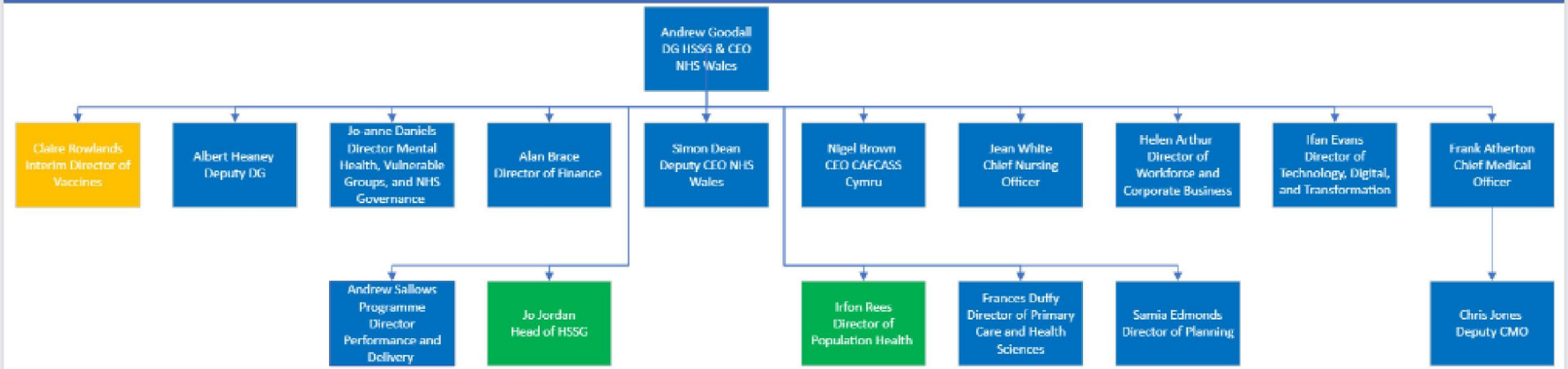
HSSG Executive Director Team as of **January 2020**



Notes

February 2020 – Simon Dean, Deputy CEO NHS Wales left on secondment to BCUHB and returned August 2020
February 2020: Director of Planning joins EDT – Samia Edmonds (Orange box)
March 2020 - Programme Director Performance & Delivery, Andrew Sallows joins EDT (Orange Box)
May 2020 - the post of Director of Social Services and Integration changed to Deputy Director General

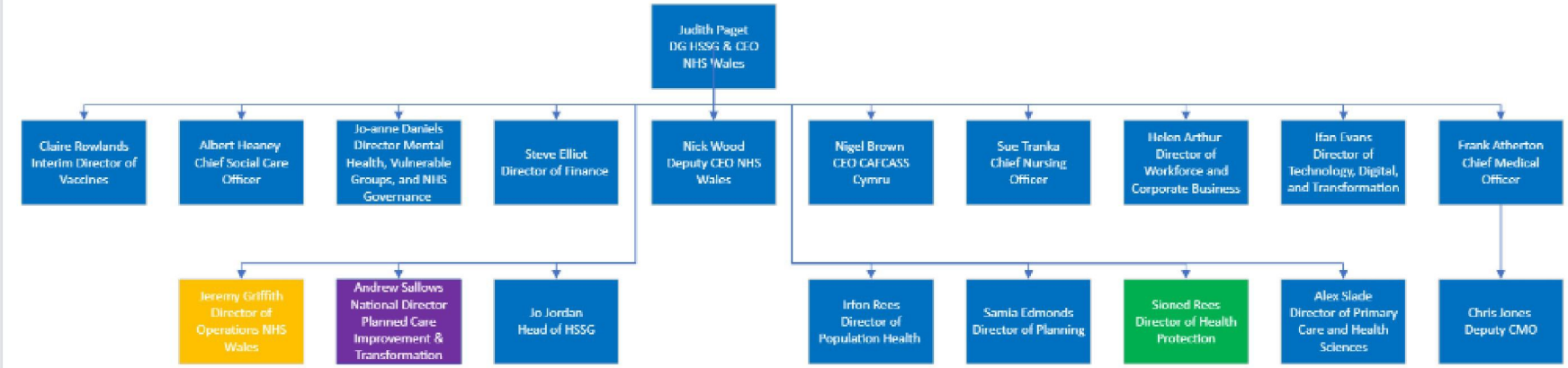
HSSG Executive Director Team as of **January 2021**



Notes

January 2021: New post added on 13th Jan 2021: Interim Director of vaccine (Orange Box)
January 2021: Tracey Breheny supporting the role of Director of Mental Health until March 2022 as Jo-anne Daniels focus on TTP.
February 2021: Deputy Director General Post changed name to Chief Social Care Officer
March 2021: Chief Nursing Officer Jean White retires. Gareth Howells takes up interim CNO role until August 2021
June 2021: Director of Finance Alan Brace secondment ends, Steve Elliot takes up post on interim basis until March 2023
June 2021: New posts created: Head of HSSG Group (Jo Jordan) and Director of Population Health (Irfon Rees) (Green boxes)
August 2021: Sue Tranka takes up Chief Nursing Officer post
October 2021: Frances Duffy retired. Alex Slade takes up interim Director of Primary Care post.
November 2021: DG Andrew Goodall becomes Permanent Secretary, Judith Paget becomes DG/CEO NHS Wales

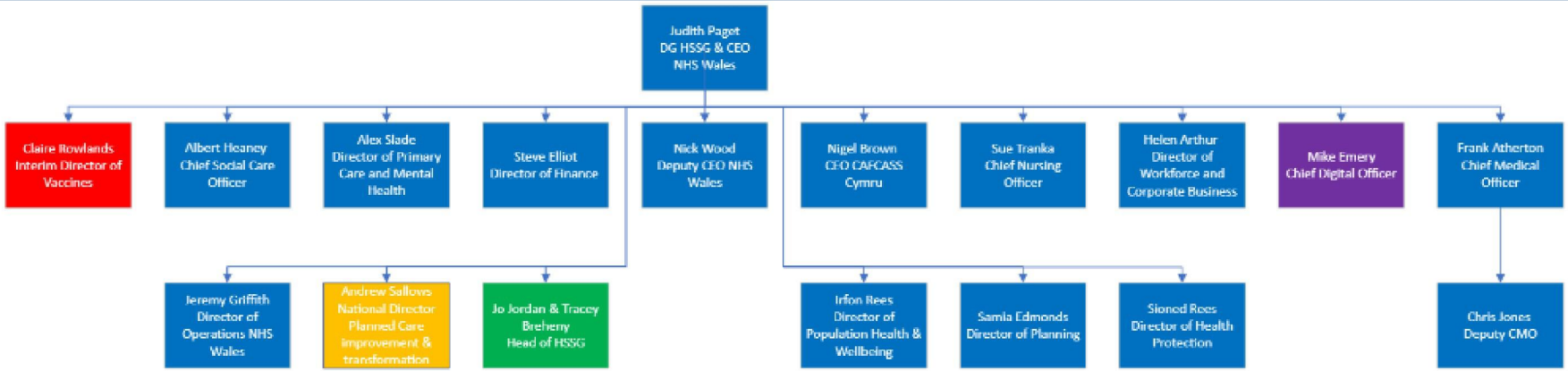
HSSG Executive Director Team as of **January 2022**



Notes

March 2022: Ifan Evans left post. Post re-named Chief Digital officer. Post vacant until Jan 2023
March 2022: Jo-anne Daniels left post. Director of Mental Health post merged with Director of Primary Care. Alex Slade appointed Director Primary Care and Mental Health.
March 2022: NHS Programme Director Performance & Delivery post becomes National Director for planned care improvement and transformation. (Purple box)
April 2022: Director of NHS Performance and Assurance joins EDT– Jeremy Griffith (Orange box)
May 2022: New post created - Director of Health Protection. Sioned Rees takes up post (Green box)
June 2022: Director of Population Health post becomes Director of Population Health and Wellbeing

HSSG Executive Director Team as of **February 2023**



Notes

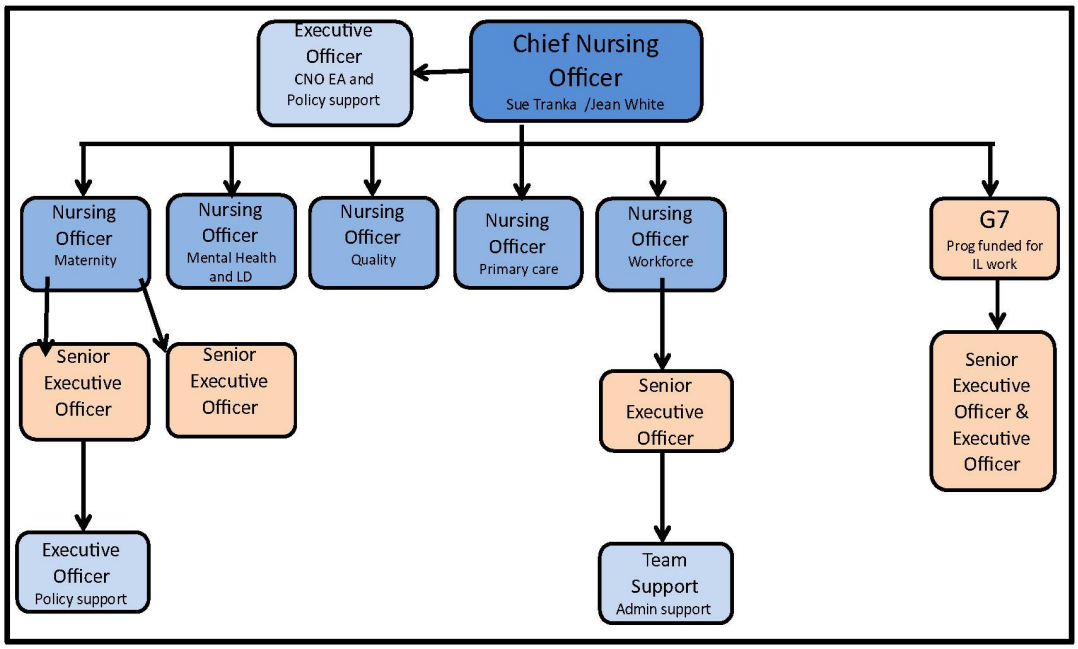
January 2023: Mike Emery takes up post as Chief Digital Officer (purple box)
January 2023: Tracey Breheny takes up post as Director and job share with Jo Jordan as Head of HSSG (green box)
January 2023: Director of vaccination post ends (red box)
February 2023: National Director of planned care post no longer sits on EDT (Orange Box)

42. The Nursing Directorate, which sits within the HSSG, provides leadership for the nursing and midwifery professions in Wales and the services they deliver. The team provides professional advice to the Minister for Health and Social Services, Deputy Ministers, and Welsh Government officials on a range of issues related to the delivery of care, as well as leading and supporting specific policy areas.

43. As Nurse Director of NHS Wales, the CNO(W) works with NHS leaders to drive improvements in care and to deliver the Programme for Government (exhibited in **M3CNOW01/01-INQ000066133**), which sets out the commitments made by the Welsh Government for its term in office and A Healthier Wales (exhibited in **M3CNOW01/02-INQ000066130**), the Welsh Government's plan for the future of health and social care which promotes a whole system approach, published in June 2018.

44. The CNO is the leader of a small directorate comprising nursing officers, who each offer professional advice to policy making departments and lead policy development in the few specific areas that fall to the jurisdiction of the OCNO(W), namely maternity services, breastfeeding, health visiting services, school nursing services, patient experience in NHS Wales, the Nurse Staffing Levels (Wales) Act 2016, health of people with learning disability, and NHS Wales safeguarding procedures, including oversight of the NHS Wales Prevent coordinators. The nursing officers, and their primary areas of responsibility, are outlined below in paragraph 49. The professional priorities for nursing and midwifery practice are delivery of the Welsh Government's Strategic Vision for Maternity Services in Wales. The Welsh Government's Strategic Vision for Maternity Services in Wales is exhibited in **M3CNOW01/03-INQ000353471** and sets out the Welsh Government's vision for maternity services in Wales as a service which promotes pregnancy and childbirth as an event of social and emotional significance where women and their families are treated with dignity and respect. As regards the professional priorities, these include monitoring Health Boards' performance against all Wales outcomes indicators and performance measures.

45. The nursing officers are supported in their work by a small team of junior civil servants. We have reproduced below a structure chart showing how the Nursing Directorate was organised during the pandemic period up to 25 April 2022.



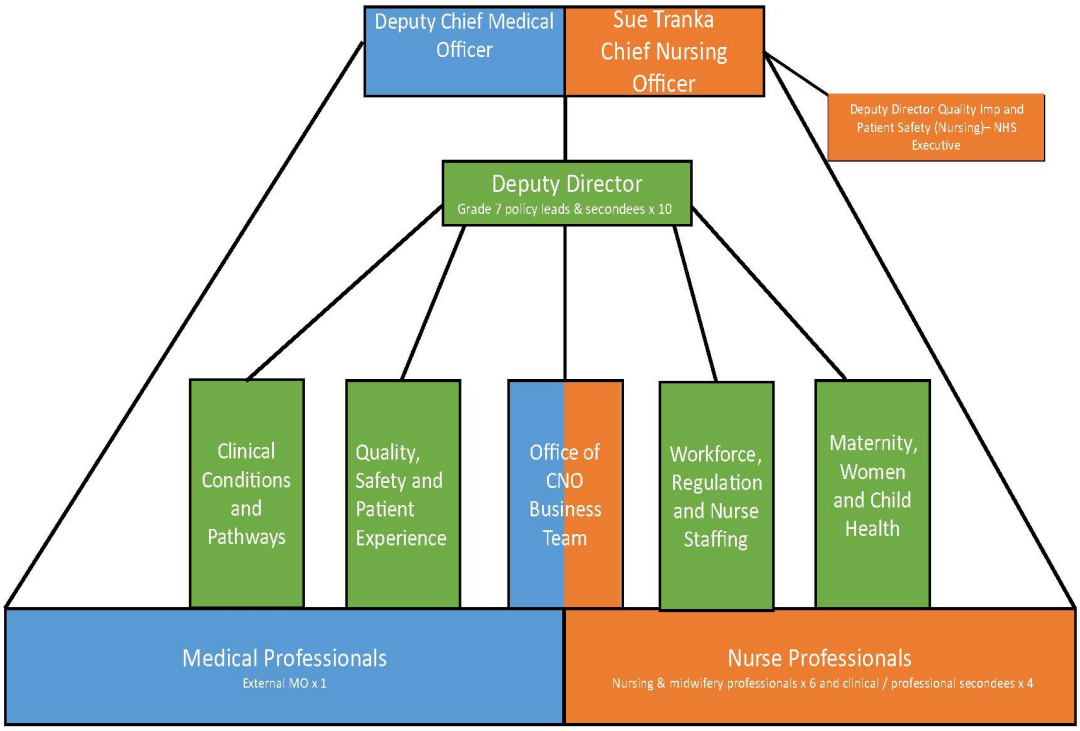
Sue Tranka

46. Since 25 April 2022, the Nursing Directorate, has been known as the Quality and Nursing Directorate and has merged with the Population Health Division of the Chief Medical Officer's directorate. The Quality and Nursing Directorate is led by the Chief Nursing Officer for Wales and the Deputy Chief Medical Officer. A newly appointed Deputy Director, Claire Rowlands, also now works across the Directorate to support us with connecting and aligning the respective remits of policy leads and nursing

officers. The Deputy Director has direct oversight of the five policy and functional areas making up the Directorate: Clinical Conditions and Pathways, Quality and Safety and Patient Experience, Women and Children's Health, Nursing Professional Regulation, and Workforce. The Directorate is organisationally positioned under the Health and Social Services Group, in the Welsh Government. Judith Paget, Director General of Health and Social Services, leads the Health and Social Services Group and is my direct line manager.

47. The Quality and Nursing Directorate's remit is large and covers, in addition to the nursing responsibilities set out above, responsibility for policy on palliative and end of life care, maternity and neonatal care, major health conditions e.g. Diabetes, long Covid, neurological conditions, implementation of the Quality and Engagement Act 2018, the duties of candour and quality, creation of Llais (Citizen Voice Body), NHS governance and several additional and aligned priorities as set out in A Healthier Wales.

48. The organogram below sets out the structure since 25 April 2022:



Key officials supporting the Chief Nursing Officer during the relevant period

Jean White, Gareth Howells and Sue Tranka

49. The Chief Nursing Officer for Wales is assisted by a team of Nursing Officers who are all appointed as below Senior Civil Service level: -

    a. NR appointed as Midwifery Adviser and Policy Head for maternity services, development of health visiting services, and school nursing services on 30 November 2018. NR worked with the policy leads for neonatal services, quality & safety, child health, and childhood vaccination, which all sat in the CMO(W)'s directorate. She also worked with the Education Department due to the interface between teachers and school nurses, and externally with Public Health Wales officials on areas like breastfeeding, childhood vaccinations, and early years programmes.

On 5 May 2022, this position was renamed Chief Midwifery Officer for Wales, but the substantive role remained the same. School nursing, health visiting, and community children's nursing were moved to a dedicated policy lead within the Directorate on 9 January 2023.

b. Name Redacted appointed Nurse Adviser for out of hospital nursing care on 1 November 2021. NR worked mainly with the Primary Care Directorate headed by Frances Duffy, Director of Primary Care and Health Science, and the policy leads for care homes in the Social Services Directorate headed by Albert Heaney, then Deputy Director General of Social Services & Integration ("Deputy Director General, SS&I"). Name Redacted also co-chaired the Primary and Community Planning and Response Sub-Group and deputised for the CNO with delegated responsibility at meetings of the Health and Social Care Planning and Response Cell.

c. NR appointed as Nurse Adviser for mental health nursing, learning disability nursing and policy lead for improving the health of people with learning disabilities on a secondment basis on 2 March 2020. NR had oversight of a three-person team addressing the recommendations from the cross-Welsh Government review of policies that address the needs of people with a learning disability, called Improving Lives. I produce here, as exhibit **M3CNOW01/04–INQ000300070**, a report on the improving lives programme, dated June 2018 which sets out a series of recommendations such as to reduce health inequalities, to improve community integration and to enable improved strategic and operational planning and access to services through streamlined funding, better data collection, partnership working and more training and awareness. NR worked mainly with the Mental Health Directorate (headed by Jo-Anne Daniels, Director of Health, Vulnerable Groups and NHS Governance) and the Social Services Directorate (headed by Albert Heaney, Deputy Director General, Social Services & Integration) in relation to learning disability, and the Education Department and several other directorates in relation to

school age children and special education needs. Name Redacted has now left the organisation.

d. Name Redacted appointed part-time Nursing Officer, advising on mental health and providing support to the mental health policy team on a secondment basis on 24 May 2022. NR has now left the organisation.

e. Name Redacted appointed on 2 January 2018 as Nurse Adviser for education and training of nursing staff, NHS Wales safeguarding procedures (including oversight of NHS Wales Prevent coordinators), and implementation and expansion (to cover paediatric wards) of the Nurse Staffing Levels Wales (2016) Act. NR worked with the Workforce & Organisational Development Directorate (headed by Helen Arthur, Director of Workforce and Corporate Business) and the quality and safety team in the CMO(W)'s directorate. She also worked with Health Education and Improvement Wales, and the Council of Deans Wales.

f. Gareth Howells (prior to his role as interim CNO), appointed on 1 August 2020 as a Nurse Adviser for patient experience in NHS Wales, which included hospital catering and patient nutrition & hydration, continence management, prevention of falls in NHS Wales settings; preventing healthcare acquired infections, prevention of tissue damage and the management of serious incidents reported in NHS Wales settings. Gareth worked with the quality and safety team in the CMO(W)'s directorate, and the infection prevention team at Public Health Wales. In September 2021, Gareth returned to his previous role on secondment as Executive Director of Nursing and Patient Experience at Swansea Bay University Heath Board.

g. Name Redacted appointed on 10 January 2022 as a Nursing Officer with policy responsibility for quality, safety and patient experience including professional advice in this area as well as support provided to the wider

HSSG. NR stepped into the role vacated by Gareth Howells when he returned to Swansea Bay University Health Board.

h. Name Redacted appointed on 7 February 2022 as a part-time Nursing Officer, advising on learning disabilities and providing support to the learning disability team.

50. We have been asked to describe the roles and responsibilities of the 'Deputy Chief Nursing Officer(s)'. The office of the CNO in Wales does not have a formal Deputy CNO role reporting into them. There are no formal delegations over and above the responsibilities and delegations of the Nursing Officers described above.

51. We have also been asked to describe the role of 'Head of Midwifery Services at NHS Wales'. This is not a term or role used in Wales and there is no single Head of Midwifery position for NHS Wales. Each of the seven Local Health Boards has its own Head of Midwifery and they engage with the office of the CNO through the Nursing Directors meetings and through the regular Heads of Midwifery meetings led by NR, also known as the All Wales Heads of Midwifery Advisory Group.

Sue Tranka

52. Once I joined the Welsh Government, I worked with officials across the HSSG but closely with the following individuals during the relevant period: -

a. Professor Chris Jones, Deputy Chief Medical Officer who provided joint cross-professional leadership on infection prevention and control, particularly to minimise nosocomial transmission in closed settings. We were co-chairs of the Nosocomial Transmission Group and following a restructure joined me in leading the Quality and Nursing Directorate.

b. Name Redacted Head of Health Care Associated Infections and Blood Safety also frequently linked in with myself and my wider team and fed into the Nosocomial Transmission Group (described in detail later in this statement). We also engaged on advice to the NHS on the Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HCAI) improvement goals as set out in the Welsh Health Circular issued on the

27 September 2021 and exhibited in **M3CNOW01/05–INQ000353276**. The Welsh Circular, which was sent to the NHS in Wales, also outlined the importance of implementing Infection Prevention and Control measures and key guidance.

Meetings and groups attended by the CNO

Jean White, Gareth Howells and Sue Tranka

53. In addition to those we describe below, details of the CNO's relationship with the following bodies are set out later in this statement:

    a. Office of the Chief Medical Officer for Wales ("OCMO");

    b. Director General, Health and Social Services Group and Chief Executive of NHS Wales ("DGHSS");

    c. Chief Scientific Advisor ("CSA");

    d. Welsh Health Specialist Services Committee ("WHSSC");

    e. Directors of Nursing in NHS Wales;

    f. United Kingdom Health Security Agency ("UKHSA"); and

    g. Health Protection Advisory Group ("HPAG").

    h. Nursing and Midwifery Council ("NMC");

    i. Welsh Nursing and Midwifery Committee;

    j. Royal College of Nursing Wales ("RCN");

    k. Royal College of Midwives ("RCM");

    l. Health and Social Care Professions Council ("HCPC").

Jean White

54. Prior to the Covid-19 pandemic:

a. I chaired monthly meetings with the Nurse Directors. I also chaired six-monthly performance meetings with the clinical leads and senior executives responsible for maternity services in NHS Wales organisations.

b. I attended weekly meetings of the HSSG Executive Director Team (EDT). The membership of the EDT is illustrated in the charts produced above. I had regular meetings on an informal basis (not minuted) with the CMO and with the Deputy CMO outside of the EDT meetings to discuss areas where our portfolios intersected. I, or one of my nursing officers, would regularly attend the CMO-led Directorate meetings where the Deputy Directors/heads of health professions met to discuss professional matters (these were not minuted). The Chief Scientific Adviser for Health was usually present at the heads of health professions meetings. I normally did not meet the CSA for Health other than at this meeting or other group meetings where he was also a participant.

c. I attended monthly meetings of the NHS Wales Executive Board which was chaired by the Director General. Members included Welsh Government HSSG Directors and the Chief Executives of NHS Wales Health Boards, Trusts and Special Health Authorities.

d. I rarely met officers from the Welsh Health Specialist Services Committee, apart from exploring what they could assist with regarding the delivery of the Improving Lives programme recommendations, such as commissioning new secure placements for people with learning disabilities in Wales.

e. I had meetings with the Directors of the Royal College of Nursing and Royal College of Midwifery approximately quarterly, as well as attending their meetings with the Minister for Health and Social Services.

f. I normally delegated attendance to the quarterly meetings of the Welsh Nursing and Midwifery Advisory Committee to one of my Nursing Officers.

g. I normally attended, and jointly chaired with the CMO, the Health Professions Advisory Group, held every 4-6 months, which was made up of the chairs of all of the statutory health professional advisory committees.

h. I normally attended the annual meeting the Health Professions Advisory group representatives had with the Minister for Health and Social Services.

i. The UK CNOs would have professional meetings on a quarterly basis to discuss professional matters. Normally we would invite a representative from the Nursing and Midwifery Council, such as the CEO/Registrar to attend part of the meeting. I normally asked one or more of my Nursing Officers to act as observers to the Nursing and Midwifery Council meetings and any of its sub-groups, such as the Midwifery Group.

j. My directorate did not have regular contact with the Health and Social Care Professions Council or other UK professional regulators, nor did we have contact with the United Kingdom Health Security Agency.

55. I have described my role in Covid-19 specific groups and meetings later in this statement.

Gareth Howells

56. All directors within the Health and Social Services Group met regularly to discuss issues affecting the planning and delivery of health and social care services, finance, ministerial priorities, press coverage, and future strategic direction. I attended weekly EDT meetings and monthly NHS Executive Board meetings. Meetings were led by the Director General, HSS. In response to the ongoing public health emergency, caused by the Covid-19, these meetings maintained a focus on the delivery of Health and Social Care, as well as any emerging urgent issues related to the pandemic.

57. I attended monthly Leadership Board meetings, which are attended by the membership of the EDT and by NHS Wales CEOs. I also became a member of the NHS Planning and Response Cell.

58. Monthly meetings took place with the Welsh Executive Directors of Nursing with the same purpose, to share information and be alerted to specific service issues that may require a Welsh Government response.

59. I also joined the virtual meetings of the UK Governments' senior clinicians, chaired by the Chief Medical Officer for England ("CMO(E)"). This group shared the latest scientific advances to help understanding and ensure a consistent UK approach across devolved administrations, where possible.

60. As interim CNO(W), I jointly chaired the Nosocomial Transmission Covid-19 Group ("NTG") with Dr Chris Jones, the Deputy Chief Medical Officer for Wales ("DCMO(W)"). As described later in this statement, this group had a wide health and social care membership and produced a range of guidance and advice for NHS and social care settings.

Sue Tranka

61. I have been part of the following groups in respect of the Welsh Government's pandemic response and decision making: -

    a. Weekly EDT and EDT Contingency meetings. The membership of the EDT is illustrated in the charts produced above.

    b. Regular performance and oversight meetings, such as Integrated Quality, Planning and Delivery ('IQPD') meetings, however more recently I have delegated this responsibility to Nursing Officer **Name Redacted**

    c. Six-monthly performance meetings with joint NHS executive teams and EDT called the Joint Executive team (JET) meetings.

d. Monthly leadership board meetings, which are attended by the membership of the EDT and by NHS Wales CEOs.

e. Monthly meetings I chair with the Nurse Directors which mainly cover areas related to the professional agenda, education, maternity and children policy updates, and operational challenges experienced. During the resurgence of Omicron variant, I started holding weekly, 30-40 minutes virtual meetings with the Nurse Directors. The purpose of these meetings was to share information and be alerted to specific service issues that may require a Welsh Government response.

f. Regular monthly one-to-one meetings with all Health Board and Trust Directors of Nursing across the Welsh system, including the Special Health Authorities.

g. The Nosocomial Transmission Group, which is described in detail later in this statement.

h. Black, Asian and Minority Ethnic Covid-19 Advisory Group: I had no direct involvement in the work of the First Minister's Black, Asian and Minority Ethnic Covid-19 Advisory Group, or the Black, Asian and Minority Ethnic Covid-19 Scientific Subgroup. I understand the Nursing Officer for learning disabilities at the time had some involvement in the work and that the previous Chief Nursing Officer was consulted on specific matters such as DNACPR (do not attempt cardiopulmonary resuscitation). The work of this group has been important and since I have taken up the post in the Welsh Government, I have supported work on the wider Anti-Racist Wales Action Plan, which continues to take forward the learning from this group.

Role of the CNO in a public health emergency

Jean White, Gareth Howells and Sue Tranka

62. The CNO(W) did not have a specific role in respect of public health emergencies but was part of the collective response staged by the Welsh Government, with the support of Public Health Wales.

Jean White

63. I was not involved in pre-pandemic planning meetings, but I was a member of the CMO(W) and Public Health Wales led Health Protection Advisory Group, established in February 2018, that provided multidisciplinary multiagency advice on all potential public health challenges. The Health Protection Advisory Group is discussed further later in this statement.

64. I think the CNO should be involved in public health emergency planning in order to give a professional perspective on areas related to their portfolio, such as nursing and midwifery workforce and deployment; amendments to nursing and midwifery education delivery and infection prevention advice, including nosocomial transmission, in health and care settings.

Gareth Howells

65. The role of the CNO(W) and Nurse Director, NHS Wales entails setting the professional agenda and future direction for the nursing and midwifery professions in Wales and acting as a senior adviser to the Welsh Ministers on all matters relating to nursing and midwifery practice and education.

66. In this public health emergency, my focus was to ensure within the context of Covid-19 that the main components of the role were maintained, and there was a major focus on the NHS and Welsh Government response as well as the provision, as far as possible, of visible support to the NHS, the Senior NHS Teams, and the services provided.

Sue Tranka

67. I was not directly involved in planning for a public health emergency as the role of the CNO(W), as stated above, excludes specifics related to public health emergency preparedness and planning. I too think that the CNO(W) should be involved in public health emergency planning in order to give a professional perspective on areas related to their portfolio, such as nursing and midwifery workforce and deployment; amendments to nursing and midwifery education delivery and infection prevention advice, including nosocomial transmission, in health and care settings.

How the role, function and responsibilities of the CNO changed during the relevant period

Jean White

68. All Executive Directors within the Health and Social Services Group (referred to as the EDT) met weekly prior to the Covid-19 pandemic to discuss issues affecting the planning and delivery of health and social care services, finance, ministerial priorities, press coverage, and future strategic direction. Meetings were led by the Director General, HSS. Once it became clear that Wales was facing a public health emergency, caused by the Covid-19 virus, these meetings were supplemented from 16 March 2020 by daily virtual meetings to address any emerging urgent issues. I produce here as exhibit **M3CNOW01/06–INQ000300091** the draft minutes of those daily virtual meetings for the period 16 March 2020 to 13 July 2020.

69. From the week commencing 16 March 2020 onwards, I started holding twice weekly, 30-40 minutes virtual meetings (on Wednesdays and Fridays) with the Nurse Directors. The purpose of these meetings was to share information and be alerted to specific service issues that may require a Welsh Government response. I exhibit the minutes from the meeting dated 18 March 2020 with the Nurse Directors at **M3CNOW01/07–INQ000299025**. As outlined in those minutes, matters such as visiting times, access to hospitals and facilities, mobilising students and NMC Return to Practice Guidance and Nursing Staffing Levels (Wales) Act 2016 were discussed.

70. I became a member of the NHS Planning and Response Cell, chaired by Samia Saeed-Edmonds, Planning Programme Director, Welsh Government Planning and Delivery Directorate, in March 2020. This cell had been established during the week commencing 24 February 2020 with NHS planners and corporate operational managers, for the purpose of considering the day-to-day impact of the pandemic on NHS service delivery, and it helped to advise the Welsh Ministers on areas where decisions were needed. I produce here, as exhibit **M3CNOW01/08–INQ000066198**, the terms of reference of the NHS Planning and Response Cell. As noted in the terms of reference, the objectives of the NHS Planning and Response Cell were to share national information, including latest risk assessment, to examine and seek to address sector concerns, to clarify and set out key planning and response structures and to identify appropriate contingency measures going forward.

71. I asked **Name Redacted** nursing officer for out of hospital care, to head up a Primary and Community Care Covid-19 Cell, with **Name Redacted** a GP, to coordinate primary and community services responses. I produce here as exhibit **M3CNOW01/09–INQ000298997**, the terms of reference of the Primary and Community Care Covid-19 Cell. As noted in the terms of reference, the aim of the Primary and Community Care Covid-19 Cell was to provide strategic co-ordination of primary and community services arrangements for Covid-19, including planning for the reasonable worst-case scenario. A paper was presented to EDT on 10 June 2020 that described the impact of Covid-19 on the delivery of community and primary care nursing services. It was agreed by the EDT that the Minister for Health and Social Services should be asked to fund a national nursing lead for primary and community care. I produce here as exhibits **M3CNOW01/010–INQ000300092, M3CNOW01/011–INQ000300093** and **M3CNOW01/012–INQ000299376,** the minutes of the EDT meeting on 10 June 2020, the ministerial advice submitted to the MHSS (MA/VG/1746/20), and the Minister's response to that advice agreeing the recommendation, respectively. The Primary and Community Care Covid-19 Cell developed the proposal that asked for this post to be established to help with the response to Covid-19 in primary and community care and delivery of the pathway they had developed. It was agreed to appoint an individual for a two-year period, and then review effectiveness. **Name Redacted**

Name Redacted was appointed to this post in early 2021, reporting to the national director and strategic lead for primary care and to the CNO(W). The appointment is hosted by Aneurin Bevan University Health Board and is still current.

72. NR, midwifery officer, also set up regular meetings with the NHS Wales Heads of Midwifery Services, Health Visiting Services, Community Children's Nursing Services and School Nursing Services. The primary purpose of these meetings was to provide forums for information sharing and were mainly focused on operational issues that affected service delivery. I did not attend these meetings and delegated responsibility to NR to work with the heads of service. She had the option to either deal with issues raised or escalate them, if a broader policy response was needed.

73. I asked Name Redacted nursing officer, to support the First Minister's Black, Asian and Minority Ethic Covid-19 Advisory Group, chaired by Professor Keshav Singhal and Helen Arthur, Director of the Workforce & Organisational Development Directorate. This group was established on 29 April 2020. This group issued its first guidance after two weeks of work and issued the Covid-19 workforce risk assessment tool for use within NHS Wales and with social services staff on 27 May 2020. I produce here, as exhibit **M3CNOW01/013–INQ000299409**, the Covid-19 workforce risk assessment tool.

74. I had some involvement with the Covid-19 Moral and Ethical Advisory Group Wales ("CMEAG"), led by Dr Heather Payne, which was established to look at the ethical values and principles that should underpin the work of health professionals during the Covid-19 pandemic. I produce here the written statement made by the Minister for Health and Social Services, the Minister for Housing and Local Government, and the Deputy Minister and Chief Whip dated 14 April 2020 on the work of CMEAG, as exhibit **M3CNOW01/014–INQ000349329.** The written statement outlined that purpose of CMEAG was to advise on issues relating to moral, ethical, cultural and faith considerations, and to provide a source of advice to health services to inform

equitable and just management of issues arising from the health care emergency response to the Covid-19 pandemic.

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

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

77. During the pandemic, most new policy work was either stopped (such as commissioning new secure placements for people with learning disabilities in Wales), suspended (for example delivery of the Improving Lives programme) or had the timetable delayed, (such as the extension of the Nurse Staffing Levels (Wales) Act). My attention, and that of the Nursing Directorate, was wholly focused on supporting the Welsh Government's response to the Covid 19 pandemic, as it emerged and took hold of the country. I felt it important that I personally support the Executive Nurse Directors in the NHS organisations to enable them to make decisions about the delivery of care.

Gareth Howells

78. I feel it is important to explain that I only undertook the role of Interim Chief Nursing Officer for Wales for approximately five months, during the period from April to August 2021, and on an interim basis. Consequently, I very much saw my role as ensuring that the Nursing Directorate continued to operate smoothly and effectively, while ensuring stability, until such time as Professor White's successor had been appointed and took up post.

79. I was cognisant of the fact that the new Chief Nursing Officer, once appointed, would likely have their own priorities, ways of working, and approach, and didn't feel that it would be appropriate in those circumstances for me to make significant changes in the Directorate during my short tenure as ICNO(W). I therefore saw my role as maintaining a "steady-ship" while my replacement was recruited, particularly as by the time I took up my role as ICNO(W), we had achieved something of a Covid-19 steady state, and many of the key decisions around the Welsh Government's pandemic response, key policies, and public health advice to professionals and the public, had already been implemented by my predecessor.

80. Additionally, unlike my predecessor and my successor, I held the position of ICNO(W) in addition to meeting all the requirements of my substantive role as a Nursing Officer within the Welsh Government. Consequently, much of my time was consumed with undertaking those duties, while ensuring that the functions of the Office of the Chief Nursing Officer were maintained.

Sue Tranka

81. As I came into the role late in the relevant period, I am not able to comment on how the role changed as a result of the pandemic. I am able to comment that I envisaged a much stronger role for the CNO in leading the quality and safety agenda, and in providing the voice of nursing into several policy areas, which is why the decision was made to join the Population Health and Nursing directorates into a single

directorate in April 2022, as it was felt that the working relationship of the CNO(W) and CMO(W) needed to be strengthened around joint working agendas.

The CNOs' role in decision-making and providing advice related to healthcare systems in Wales during the relevant period

Jean White

82. The First Minister ("FM") asked civil servants in Wales to identify what work could be paused, or stopped, to free up resources that could be redeployed to the pandemic response. A list was agreed at the EDT meeting on 19 March 2020, and subsequently submitted to the FM for agreement. I produce here, as exhibit **M3CNOW01/015–INQ000353494** the minutes of the EDT meeting on 19 March 2020, during which an update on Covid-19 was given and the rising number of cases, and the list of activities which the HSSG proposed to pause as exhibit **M3CNOW01/016–INQ000353493**. This included a range of activities including work across the health sector, finance and digital and also provided an indication of the likely duration of the pause.

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

director. Due to concerns expressed by the NHS CEOs, as reported in the meeting on 19 March 2020, the Health Boards were asked to prepare status reports on the actions they were taking to create capacity within the health system. This was reported on in the next EDT meeting on 25 March 2020 (the minutes of which I produce here, as exhibit **M3CNOW01/017–INQ000353490**. It is my recollection that ensuring appropriate levels of PPE to be delivered to local authorities and care homes remained challenging for some weeks. Albert Heaney kept in contact with the social services leads to help facilitate where possible, however supply of PPE was not just an issue for social services.

84. A Covid-19 systems risk framework ("the Risk Framework") with actions for the health and social care sectors was developed by the Department of Health and Social Services Delivery and Performance Team led by Samia Saaed-Edmunds and shared with Directors for comment. I was able to contribute my professional view before it was sent to the Minister for Health and Social Services for approval. I was in agreement with the actions outlined, though I remained anxious about the workforce pressures we were going to experience. I do not recall what was said about the evidence base used in the development of the framework, as I was not involved in that stage of production. I produce here, as exhibit **M3CNOW01/018–INQ000366593,** the ministerial advice on the Risk Framework (MA/VG/1004/20) recommending that the Minister agrees the Risk Framework, which contains national actions for local implementation. The underlying premise of the Risk Framework was to ensure system readiness, with specific thought given to protecting vulnerable groups of people, to release and reconfigure capacity in health and social care, and to rest and retrain staff who would need to be redeployed. The Risk Framework consisted of 24 actions which were as follows:

    i. Scale down non-urgent outpatient appointments and ensure urgent appointments are prioritised.
    ii. Scale down non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery),

iii. Prioritise use of non-emergency patient transport services to focus on hospital discharge and ambulance emergency response.

iv. Expedite discharge of vulnerable patients from acute and community hospitals.

v. Relax targets and monitoring arrangements across the health and care system.

vi. Minimise regulation requirements for health and care settings.

vii. Fast track placements to care homes by suspending the current protocol which gives the right to a choice of home.

viii. Permission to cancel internal and professional events, including study leave, to free up staff for preparations.

ix. Relaxation of contract and monitoring arrangements for GPs and primary care practitioners.

x. Suspend NHS emergency service and health volunteer support to mass gatherings and events.

xi. Mobilise business continuity arrangements across health and social care.

xii. Issuing and implementation of the new COVID-19 Pathway.

xiii. Ensure there is clarity on the testing of health and social care workers.

xiv. Ensure domiciliary and care home staff are able to access PPE if needed and understand when it should be used.

xv. Restrict visiting times and arrangements to acute hospitals, community hospitals, nursing and residential home.

xvi. Commence discussions with Age Cymru about the development of Ffrind mewn Angen, Friend in Need (befriending service) through all Regional Partnership Boards.

xvii. Roll-out of video consultations across a range of settings.

xviii. Commission private healthcare capacity, staff and equipment.

xix. Commence urgent discussions with hospitality and leisure sectors regarding availability of facilities and staff for: community isolation facilities; hospital discharge accommodation; staff accommodation.

xx. Refocus Regional Partnership Boards to prioritise health and social care preparedness, in alignment with Local Resilience Forums.

xxi. Scale down dental activity.

xxii. Scale down optometry activity.

xxiii. National commissioning of vacant nursing home placements.

xxiv. Scale down screening programmes to avoid harm to vulnerable groups.

The first 10 of these actions were announced in a written statement on 13 March 2020, which I produce here as exhibit **M3CNOW01/019– INQ000320755.** The remaining 14 actions were set out in an oral statement on 17 March 2020, which I produce here as exhibit **M3CNOW01/020– INQ000271921.**

85. Field hospitals in Wales were open and utilised consistently from October 2020. I discussed and agreed the staffing model being adopted with the Nurse Directors. The predominant model used across Wales was a 'step-down' service, which used a multi-professional and integrated team approach that facilitated the handover of care back to the community. This enabled provision of additional and often much needed rehabilitation to patients. Additional staff training was instrumental in enabling field hospitals to function well and empowered excellent working relationships across local teams to develop, including the integration of therapy staff into the clinical teams. Some health boards redeployed nurses with a mental health background to the sites, and reported this had worked very well, especially in supporting patients who had cognitive impairment.

86. I asked **NR** nursing officer for out of hospital care, to head up a Primary and Community Care Covid-19 Sub-Group, with **Name Redacted** a GP, to coordinate primary and community services responses. The terms of reference of the Primary and Community Care Covid-19 Cell which notes its purpose as to provide strategic co-ordination of primary and community services arrangements for Covid-19, including planning for the reasonable worst-case scenario were previously exhibited at **M3CNOW01/09–INQ000298997**. The terms of reference set out the following objectives:

a. To share national information, including latest risk assessment and advice.

b. To examine and seek to address sector concerns.

c. To clarify and set out key planning and response structures.

d. To identify appropriate contingency measures going forward.

e. To advise on strategic operational response.

87. This sub-group provided an important link between primary care and community doctors and nurses and fed into the all-Wales General Practice Nursing Forum and District Nurses Forum to promote cross-sectional co-operation between services. The Sub-Group recommended the creation of a Primary and Community Care National Nursing lead which was later approved by the Minister for Health and Social Services, as detailed in paragraph 101b.

88. In order to support the pandemic response many school nurses were redeployed when schools closed to community health nursing roles or secondary care nursing roles. Following the Minister for Education's announcement that pupils would be returning to schools on 29 June 2020, I asked the Nurse Directors at our meeting on 9 June 2020 to make plans to stand up their school nursing services and return redeployed staff to their substantive roles. I produce here the minutes of that meeting as exhibit **M3CNOW01/021–INQ000299375**. This would prove to be difficult as many of the school nurses could not be released from their alternative roles immediately and therefore it took some time for normal support to be fully established. In the autumn term the school nursing services were again running, although there were still a small number of gaps due to some school nurses having not yet returned to their posts. The joint operational heads of health visiting, and school nursing meetings continued bi-monthly throughout 2020, with reports submitted to my office's lead, **NR**. It was important that the normal national screening and immunisation programmes be reintroduced as soon as possible. It was good to see

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

89. My role in decision-making and advice through the Nosocomial Transmission Group is described later in this statement.

90. Throughout this time, I was given opportunities to actively contribute a professional view to the guidance developed to support changes in NHS Wales in order for it to respond to the challenge of the pandemic as it spread through communities in the various waves. I felt my views were welcomed and on the whole accepted. I did not get involved in the wider public health work such as social distancing, travel, lockdown decisions, etc., nor was I involved with data collection or modelling work, procurement of equipment, PPE or the operational work to set up field hospitals. This was delegated to appropriate teams with the expertise to address the issues. I only had limited involvement in issues affecting the care home sector, including discharge criteria, and this was not in the early stage of the pandemic.

Gareth Howells

91. It is important to note that governance arrangements and structures are in place within the Welsh Government for the purpose of decision-making. Significant decisions are rarely, if ever, taken by individuals and I certainly was not required to make any significant decisions personally.

92. To the extent that I was involved in providing advice to the Welsh Government during my brief time as Interim Chief Nursing Officer, Wales, this advice was provided through the appropriate structures, primary among which was the Nosocomial Transmission Group, which drew upon the best available evidence and relevant expertise from across the Welsh Government and the wider public sector in Wales.

93. To the extent that I needed to be as interim CNO, I felt fully involved in decision making, working within the appropriate structures and closely with relevant officers,

including the Deputy Chief Medical Officer, Dr Chris Jones, who held the leadership portfolio for infection prevention and control, which included Covid-19.

94. I do not recall any situations in which I personally provided advice to the First Minister, or any Welsh minister. I have also reviewed relevant records and have been unable to find any ministerial advice that I prepared during my tenure as ICNO(W).

95. I do not recall any occasions when advice which I contributed to through relevant bodies, was not followed. In my experience, the Welsh Government was guided very closely by the best available evidence on how to keep the people of Wales safe.

Sue Tranka

96. In respect of the Welsh Government's response to the Covid-19 pandemic, I should make clear that I have had no role in the Welsh Government in respect of advice upon the scientific group outputs or modelling exercises, advising the First Minister or the Minister for Health and Social Services on the timing of different stages of the Welsh Government's response to the pandemic, prediction of future Covid-19 surges, emergence of new variants, immunity responses to vaccinations, or testing.

97. I have had no meetings with the First Minister to brief him on Covid-19 related work during the relevant period.

98. My role in the pandemic response since taking up post on the 30 August 2021 has been to provide advice to the Minister of Health and Social Services and to support and to advise the NHS on matters related to the implementation of infection prevention and control measures specific to the pandemic phase. I have provided advice as part of formal Ministerial Advice on Covid-19 related work and issues, submitted to the Minister for Health and Social Services. For example, I provided advice on amendments to the hospital visiting guidance in December 2021 to acknowledge that Health Boards, Trusts and Hospices are able to restrict visiting and accompanying of patients to scheduled and unscheduled appointments for the purposes of infection prevention control in response to other infectious diseases such as RSV and influenza, as exhibited in **M3CNOW01/22-INQ000116711.** I also

supported Chris Jones, Deputy Chief Medical Office in relation to proposals on the management of patient safety incidents following nosocomial transmission Covid-19 in January 2022, as exhibited in **M3CNOW01/023-INQ000116736.** In that ministerial advice, it was recommended that the Minister agrees that additional funding is given to the national implementation of the NHS Wales National Framework: The Management of Patient Safety Incidents. Additionally, in April 2022 I provided advice relating to updates to the maternity and neonatal visiting guidance, as exhibited in **M3CNOW01/24-INQ000116751.** In that ministerial advice, it was recommended that the maternity and neonatal visiting guidance is updated to support local services when planning and implementing their visiting arrangements for maternity and neonatal services.

99. The Deputy Chief Medical Officer and I have also advised the Minister for Health and Social Services on matters related to the management of Covid-19 nosocomial transmission, healthcare associated infections (HCAI) and in particular the de-escalation of infection prevention and control measures in May 2022. For example, on 20 May 2022, the Deputy Chief Medical Officer for Wales and I issued a joint letter to NHS Wales providing advice on the de-escalation of Covid-19 measures to enable the transformation and modernisation of planned and elective care, and to reduce waiting times. This is described in more detail later in this statement.

100. Since taking up post in 2021, I can confirm that, in relation to my current role and responsibilities, the Welsh Government has adequately involved me in discussions and decision making in its response to the pandemic. I have felt included in all leadership and Executive discussions and was asked for advice and support specifically regarding nursing and patient safety concerns. I do feel, however, that on a systemic level, there are opportunities for the CNO to play a more central role alongside the CMO in decision-making for pandemic preparedness to enable a more comprehensive focus.

Formal Ministerial Advices submitted by the Nursing Directorate

Jean White, Gareth Howells and Sue Tranka

101. In terms of formal advice provided or submitted during this period by the Nursing Directorate in relation to the response of the healthcare system to the Covid-19 pandemic, this was limited to the following:

    a. 19 March 2020 – Advice on Covid-19 disruption to the Nurse Staffing Levels (Wales) Act 2016 (MA-VG-0994-20) is exhibited at **M3CNOW01/025-INQ000367343**. The advice sets out that the Nurse Staffing Levels (Wales) Act 2016 (the 2016 Act) places a duty on health boards and NHS trusts to calculate and maintain the nurse staffing level for adult acute medical inpatient wards and adult acute surgical inpatient wards, together with a regulation making power to extend the duty to calculate and maintain nurse staffing levels to other care settings. Prior to the pandemic, there was ongoing preparatory work to extend the duty in the 2016 Act to paediatric inpatient wards. The ministerial advice sought ministerial direction to revise the legislative timescales on extending the duty to paediatric inpatient wards and to agree consistent lines of assurance to health boards around their existing duties. The Minister's decision agreeing the proposal is exhibited at **M3CNOW01/026 - INQ000299029.**

    b. 4 June 2020 – Advice on establishing a new National Nursing Lead for Primary and Community Care post within the National Primary Care Leadership Team. Exhibits previously disclosed in this statement at **M3CNOW01/011–INQ000300093** and **M3CNOW01/012-INQ000299376**, set out advice (MA/VG/1746/20) submitted to the Minister for Health and Social Services and the Minister's response to agreeing to the advice to establish a new National Nursing Lead for Primary and Community Care post within the National Primary Care Leadership Team. The advice to the Minister recognised the impact of the pandemic noting that the Covid-19

primary care pathway set out four key ways of working to support an effective Covid 19 response:

i. Self-care and self-management at home

ii. Supportive care delivered in the home, GP surgery or cluster hub by a multi-professional team serving a cluster population.

iii. Palliative care delivered in the home, by a multi-professional cluster supportive care team.

iv. Referral to an acute hospital.

Primary and community nursing services were integral parts of the multi-disciplinary teams needed to deliver the first three elements listed. The appointment of a National Nursing Lead Primary & Community Care would provide leadership to support this pathway.

c. 3 November 2020 – Update to guidance on hospital visiting during Coronavirus (MA-VG-1459/20). This ministerial advice sets out advice to the Minister for Health and Social Services to update hospital visiting guidance to allow health boards and trusts discretion when agreeing visiting requests to consider the well-being of the patient or visitor in view of variations in community transmission across different parts of Wales and differences in the rates of nosocomial transmission. The ministerial advice is exhibited at **M3CNOW01/027–INQ000136825**, the Minister's approval at **M3CNOW01/028–INQ000299690** and a statement on 30 November 2020 to alert Members of the Senedd and the public to the most recent changes to the guidance at exhibit **M3CNOW01/029–INQ000300096.**

d. 7 December 2020 - Advice on members debate on supporting children and families during the pandemic and perinatal mental health (MA-VG-4232-20) is exhibited at **M3CNOW01/030–INQ000144937**. This ministerial advice provides information about a debated tabled by Lynne Neagle MS

calling on the Senedd to recognise the significance of supporting children and families and recognise the importance of perinatal mental health during the pandemic, together with speaking notes and voting advice in relation to the debate.

e. 27 April 2022 - Update to Maternity and Neonatal Visiting Guidance (MA/EM/1412/22) was previously exhibited at **M3CNOW01/024-INQ000116751**. This advice sought ministerial approval to update maternity and neonatal visiting guidance to support local services when planning and implementing their visiting arrangements for maternity and neonatal services.

102. In addition to the formal advices submitted by the Nursing Directorate, the Chief Nursing Officer would also be a copy recipient of any formal advice which was submitted by other Directorates which cut across to the Nursing Directorate or had wider implications, for example advice from the Health and Social Services Technology, Digital and Transformation Directorate and Workforce Directorate. These have not been detailed here as not directly from the Nursing Directorate but a full list of all formal ministerial advices has been provided to the Inquiry.

Jean White

103. During my time as Chief Nursing Officer there were also a number of occasions where I would provide informal advice to the Minister for Health and Social Services. This advice was provided on the following occasions:

a. 29 June 2020 – Advice on extension of contracts given to student nurses and midwives. On 29 June 2020, the Minister for Health and Social Services published a written statement explaining that the three and six-month contracts given to student nurses and midwives which enabled payment for their clinical work during the pandemic would not be extended beyond the original time agreed for the contracts. The reason for not extending paid contracted work as healthcare support workers was that

there were concerns that students would not have the opportunity to complete their programmes on time in order to enter the professional register and subsequent employment as a fully registered nurse. I produce here, as exhibit **M3CNOW01/031–INQ000300021**, a copy of that written statement.

b. On 12 October 2020 I provided advice to the Minister for Health and Social Services informally via email on the position for Wales in responding to a request for mutual aid from the other nations. On this occasion the CNO(NI) contacted me at the behest of her health minister seeking mutual aid in the form of qualified nurses to come and work in the NHS NI to help with their upsurge in Covid 19 cases. I discussed this with the Minister for Health and Social Services, who agreed with my advice not to send any staff because we too were seeing an upsurge in cases and were in the process of opening Field Hospitals that required staffing. This request for aid was also declined by Scotland and England. I produce here, as exhibits **M3CNOW01/033 – INQ000299602** my advice to the Minister and **M3CNOW01/034 - INQ000299603**, and my response to the CNO(NI)'s request respectively, where I informed her that Wales would be unable to provide NI with additional nurses at the time.

c. The UK CNOs issued a joint statement on 25 March 2020 with the trade unions, professional groups that explained our collective view on the need for a different way of staffing critical care settings and the need for a team-based approach to be introduced (the letter is discussed further at paragraph 192 of this statement). From my conversations with the CNO(E) in the months following the publication of this statement, I was aware that she had been involved with changes in staffing ratios of intensive care patients, including in the temporary Nightingale hospitals. I therefore sought her views on what had been happening in clinical practice in England to assist in my preparation of ministerial advice. I recommended to the Minister for Health and Social Services that we follow the same

advice that NHS England was following, which had been produced by the UK Critical Care Nursing Alliance, but that application of the guidance was to be undertaken in consultation with the Wales Critical Care and Trauma Network. An interim position statement was made by the Intensive Care Society on 9 November 2020 which I produce here as exhibit **M3CNOW01/035 –INQ000299697.** The UK Critical Care Nursing Alliance issued an updated position statement in January 2021 which I produce here as exhibit **M3CNOW01/036 –INQ000300140.** This also refers to the UK Critical Care Nursing Alliance's November 2020 statement.

d. On 13 January 2021 I alerted the Minister for Health and Social Services to the letter sent by Matt Hancock, Secretary of State for Health to the Chief Executive of the Nursing and Midwifery Council requesting the reactivation of the emergency standards brought in during the first wave of the pandemic, and later withdrawn in summer 2020. If reactivated, it would enable 3rd year nursing students to undertake a 12-week paid placement rather than have the normal supernumerary status that facilitated their clinical learning. My advice to the Minister was to note this request but that mobilising the 3rd year students in such a way was not deemed necessary for the delivery of care in Wales at that time. I reminded him that students who wished to undertake paid employment in NHS Wales on top of their studies were enabled to do so through the Nursing Bank system. I produce here, as exhibits **M3CNOW01/037- INQ000299755** and **M3CNOW01/038 – INQ000299754** respectively, the letter from the Secretary of State to the Chief Executive of the NMC, and my advice to the Minister.

The relationship between the CNO and other relevant bodies

The Office of the Chief Medical Officer for Wales ("OCMO")

Jean White

104. The Chief Medical Officer and I attended daily meetings with the Chief Executive Officer of NHS Wales. The frequency of these meetings diminished once the initial wave of the virus receded. These meetings reverted to their normal weekly EDT arrangements thereafter.

105. The CMO and I also both attended NHS Executive Board meetings chaired by the Chief Executive Officer of NHS Wales and meetings of UK senior clinicians.

106. I co-chaired the Nosocomial Transmission Group, described further later in this statement, with the Deputy Chief Medical Officer.

107. Members of the Nursing Directorate continued their normal working arrangements with the policy leads in the office of the CMO relevant to their portfolio, such as the Independent Maternity review of Cwm Taf Morgannwg University Health Board, delivery of neonatal services, delivery of Healthy Child Wales surveillance work which is conducted by health visitors, quality and safety team reviews of critical and serious incidents.

Gareth Howells

108. I attended weekly EDT meetings and monthly NHS Executive Board meetings with the CMO and the rest of the EDT team.

109. I worked closely with Professor Chris Jones, Deputy Chief Medical Officer, who provided Welsh Government leadership on infection prevention and control. We also co-chaired the Nosocomial Transmission Group.

Sue Tranka

110. I have worked closely with Professor Chris Jones, Deputy Chief Medical Officer, who provided joint cross-professional leadership on infection prevention and control, particularly to minimise nosocomial transmission in closed settings. We were co-chairs of the Nosocomial Transmission Group and, following the April 2022 restructure described earlier in this statement, he joined me in leading the Quality and Nursing Directorate.

111. The Chief Medical Officer (CMO) and I attend weekly EDT meetings with the Chief Executive Officer of NHS Wales, along with all other members of the EDT.

112. I attended only a few of the UK Senior Clinicians meetings with the CMO after taking up post in August 2021, as these meetings were deemed unnecessary by the CMOs, and were subsequently terminated soon afterwards.

113. I am also a member of the Health Protection Advisory Group, chaired by the CMO, that provides multidisciplinary, multiagency advice on all potential public health challenges. The Health Protection Advisory Group continued to work throughout the pandemic, and I joined the meeting in my capacity as CNO in September 2021.

114. I have also attended the Professional Partnership Forum with the CMO where we meet with professional bodies such as the Academy of Welsh Royal Colleges to share insights and address issues for Welsh Government to support professional concerns.

Director General, Health and Social Services Group and Chief Executive of NHS Wales ("DGHSS");

Jean White, Gareth Howells and Sue Tranka

115. As outlined above, the CNO(W) is managed by, and reported directly to the Director General of the Department of Health and Social Services and directly advised the

Minister for Health and Social Services and the Deputy Minister for Social Services on matters related to the portfolio of responsibility described above.

Chief Scientific Advisor ("CSA")

Jean White, Gareth Howells and Sue Tranka

116. We had no reason to engage directly with the Chief Scientific Advisor or their office on matters related to Covid-19 during our respective tenures as CNO during the relevant period.

Jean White

117. I did, however, assist with the redeployment of some officers from the Nursing Directorate to the Technical Advisory Cell ('TAC') when additional resources were required early in the pandemic.

Welsh Health Specialist Services Committee ("WHSSC")

Jean White, Gareth Howells and Sue Tranka

118. WHSSC was a joint committee of the Local Health Boards, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009. WHSSC planned, secured and monitored the quality of a range of specialised services on behalf of the health boards in Wales. Officials in the Major Health Conditions policy team, (which as of April 2022 forms part of the Quality and Nursing Directorate) acted as the main interface between WHSSC and the Welsh Government, meeting the Managing Director on a regular basis to discuss areas of concern. During the relevant period, officials ensured that WHSSC was involved in the acute secondary care planning and response subgroup and essential services subgroup. From 1 April 2024, the WHSSC has been replaced by the Joint Commissioning Committee (JCC) which assumes responsibility for the services previously commissioned by the WHSSC, the Emergency Ambulance Services Committee and the National Collaborative Commissioning Unit.

Directors of Nursing in NHS Wales

Jean White, Gareth Howells and Sue Tranka

119. We chaired regular meetings with Nurse Directors from every Local Health Board, Trust and Special Health Authority in Wales where a similar role is held. These meetings, also known as The Health Board/Trust Nurse Director Forum, are a peer support, professional advisory group established as a resource to the CNO whose functions include:

    a. Ensuring nursing and midwifery moves forward in a consistent way across Wales.

    b. Sharing and taking responsibility for professional issues related to nursing and midwifery education and practice.

    c. Commissioning of work to support the activity of the Forum; and

    d. Intelligence gathering and sharing good practice.

Jean White

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

Control to issue guidance on the wearing and laundry of uniforms. I emailed the Nurse Directors with that guidance and reminded them of their responsibilities regarding changing facilities. I exhibit as **M3CNOW01/039–INQ000299158** an email, dated 14 April 2020, sent to the Nurse Directors, which includes the advice provided by Gail Lusardi in relation to the contamination of uniforms. Further examples of issue raised within these meetings are set out later in the statement.

121. Once the monthly routine meetings were reintroduced, I asked each of my nursing officers to produce a written update from their areas of responsibility to share with the Nurse Directors. This was updated for every meeting and provided links to core Welsh Government advice and policy. I produce here an example of this Nursing Directorate 'Hot Topics' briefing for November/December 2020, as exhibit **M3CNOW01/040–INQ000300123.** The exhibit shows that updates were provided by me as CNO, primary community & integrated care and innovation, maternity & early years, patient experience, learning disability improving lives programme, mental health nursing issues, and workforce regulation & service development.

122. In addition to the regular meetings, I regularly engaged with Local Health Boards and Trusts via oversight and assurance meetings and NHS Wales Board, as well as outside these meetings as needed.

123. A wide range of nursing and midwifery service specialist reference groups and networks have existed in Wales for many years (most pre-date my appointment as CNO in 2010). These groups are predominantly service leaders who meet at regular intervals to discuss issues and share good practice within their speciality, for example the Health Visitor and School Nursing group, District Nursing Forum, Mental Health and Learning Disability group, and Continence Advisors group. Many of these groups remained functional during the pandemic and were used by the members of the Nursing Directorate to gain insight into operational matters.

Gareth Howells

124. I kept in close and regular contact with the Nursing Directors to support and manage professional nursing and midwifery matters in Wales. I chaired weekly meetings with the Nursing Directors and Nursing Officers and officials in my directorate. These were key meetings which allowed for information sharing, open discussion of emerging issues and feedback from the Local Health Boards.

125. In addition to the regular meetings, I also regularly engaged with Local Health Boards and Trusts via Leadership Board meetings, as well as outside these meetings as needed.

Sue Tranka

126. As noted above, I chair monthly meetings with the Directors of Nursing from each of the NHS bodies in Wales and the Nursing Officers and Welsh Government officials from within my office. This is not a Covid-19 specific meeting but an established forum for discussion and one that supports my role as Nursing Director for Wales. During the relevant period the topic of Covid-19 was discussed at these meetings.

127. In addition to the regular meetings, I regularly engage with Local Health Boards and Trusts via oversight and assurance meetings and Leadership Board, as well as outside these meetings as needed.

United Kingdom Health Security Agency ("UKHSA")

Jean White

128. I did not attend meetings of, nor otherwise directly engage with the UKHSA, which came into existence in April 2021 at the point of my retirement, or its predecessor Public Health England. As I have described below, engagement at a UK level was predominantly conducted through meetings with the other nations' CNOs.

Gareth Howells

129. I was not involved in UKHSA meetings but I participated in meetings between the UKHSA and Chief Nursing Officers. These were not decision-making committees but forums for sharing information and horizon scanning UK impact.

Sue Tranka

130. Between August 2021 and May 2022, I regularly attended meetings of the Chief Nursing Officers. These were not decision-making committees but forums for sharing information and horizon scanning UK impact. My attendance at UKHSA meetings has been more informal and ad hoc dependent upon the concerns the CNOs had at various points of the pandemic. For example, I attended a meeting with UKHSA after it was set up in October 2021 during which I met with Jenny Harries (CEO of UKHSA) and their clinical fellow whose role it was to develop terms of reference to establish the operating overlap between the UKHSA and Wales. The Deputy CMO, Dr Chris Jones, also attended the meeting for the purpose of understanding the remit of the UKHSA as it applied to IPC guidance and policy in Wales. There were no recorded minutes of this meeting, but I recall that it was agreed that the roles and responsibilities of the UKHSA did not extend to Wales.

Health Protection Advisory Group ("HPAG").

Jean White

131. As noted above, I was a member of the Health Protection Advisory Group ('HPAG'), established in February 2018, that provided multidisciplinary multiagency advice on all potential public health challenges. The Health Protection Advisory Group continued to work throughout the pandemic, although its terms of reference were amended on 24 August 2020, with increased membership and increased frequency of meeting. I produce here, as exhibits **M3CNOW01/041–INQ000180630** and **M3CNOW01/042- INQ000320987,** the terms of reference dated February 2018 and September 2020 respectively. As outlined in the terms of reference, the establishment of the Health Protection Advisory Group was approved by the Chief

Medical Officer to secure wide integration and effective implementation of health protection policies, maintain an overview of the work of health protection and drive forward the health protection agenda in Wales.

Gareth Howells

132. As interim CNO I was a member of HPAG, attending two meetings during my tenure.

Sue Tranka

133. During the period of September 2021 to June 2022, I attended HPAG meetings as I was a member of this group, before the terms of reference were redrafted in April 2022, following which a deputy was assigned to attend the meetings on my behalf. The updated terms of reference agreed in April 2022 are exhibited at **M3CNOW01/043-INQ000421008.** The updated terms of reference maintained the group's purpose to secure wide integration and effective implementation of health protection policies, maintain an overview of the work of health protection and drive forward the health protection agenda in Wales.

The CNO's engagement with professional groups

Nursing and Midwifery Council ("NMC")

Jean White, Gareth Howells and Sue Tranka

134. The Nursing and Midwifery Council is a regulatory body that oversees the registration and practice of nurses and midwives. It is responsible for ensuring that nurses and midwives meet the required standards of education, training, and professional conduct in order to provide safe and effective care to patients. The NMC also investigates complaints and takes disciplinary action when necessary to protect the public.

Jean White

135. Early on and throughout the pandemic, as the Chief Nursing Officer for Wales, I engaged with the other UK Chief Nursing Officers and the NMC. Initially this was in relation to the redeployment of students and returners to the register in order to address potential shortfalls in the delivery of safe and effective care. Joint statements on expanding the nursing and midwifery workforce were subsequently issued and the final drafts are produced as exhibits **M3CNOW01/044 - INQ000412464** and **M3CNOW01/045 - INQ000412465**. As can be seen, the actions being put into place to deal with the emergency situation included: inviting those midwives who have left the register within the last three years to opt in; encouraging skilled midwives not working in clinical care to consider entering clinical practice; and changing the nature of the undergraduate programme so as to allow the last six months of student programmes to be delivered in a clinical placement. This was updated from time to time, for example when the Covid-19 temporary register became live on 27 March 2020, I produce the update as exhibit **M3CNOW01/046** **INQ000300100** and when the Covid-19 temporary register was expanded to overseas trained nurses on 5 January 2021, **M3CNOW01/047 - INQ000300102.**

136. On 3 April 2020 I was contacted by the NMC and asked to co-sign a letter alongside the CNO of England, Chief Executive of NMC, Chair of the Care Provider Alliance and CNO strategic advisor of Care Home Nursing. The letter was to encourage former social care nurses to return to the register to help meet the exceptional demands that Covid-19 had placed on health and social care services. The NMC felt that the letter would carry more weight if all CNOs were signatories. I agreed as did the Chief Executive of Scottish Care. I also asked Care Forum Wales and other Welsh social care groups to become signatories. A copy of my correspondence with the NMC on this issue is exhibited at **M3CNOW01/048 - INQ000412485.**

137. I continued to liaise with the NMC and co-signed another letter with the NMC and others in November 2020 to offer our support and thanks to the nursing and midwifery

professionals during the second wave of the pandemic. I exhibit a copy of this letter as **M3CNOW01/049 - INQ000412563.**

138. Throughout the pandemic the Office of the Chief Nursing Officer in Wales met and corresponded with the NMC on a variety of issues including workforce, PPE, vaccines, recovery planning and registration standards. I exhibit as **M3CNOW01/050 - INQ000412553** an email chain which includes the agenda for a meeting on 10 May 2021. Agenda items include: four country updates; DHSC regulatory reform consultation; post registration standards consultation and NMC updates. Although this meeting was the month after I retired as CNO, the agenda items reflect the types of issues which my office and the NMC discussed during my tenure.

139. The NMC provided regular updates and feedback, for example on 12 April 2020 the NMC shared its draft guidance on PPE which highlighted factors to consider when suitable PPE was not available. This included whether additional steps could be taken to minimise transmission and whether treatment could be delayed or provided remotely. I exhibit as **M3CNOW01/051 - INQ000412493** an email, dated 14 April 2020, containing a statement on PPE from the NMC. The NMC also regularly shared data on the number of registrants who were on its Covid-19 temporary register. I exhibit as **M3CNOW01/052 - INQ000412498** an email chain with emails from the NMC, which shares the following UK and Wales data:

Data breakdown total register

Part of the register	Total Registrants
Midwife	687
Nurse	11136
Nurse; Midwife	125
Grand Total	**11948**

Country of address	Total Registrant
England	9841
N Ireland	250
Scotland	1272
Wales	537
Not Given	48
Grand Total	**11948**

Wales	**537**
Midwife	**25**
1.2 Age Between 21-30	3
1.3 Age Between 31-40	2
1.4 Age Between 41-50	2
1.5 Age Between 51-55	2
1.6 Age Between 56-60	9
1.7 Age Between 61-65	6
1.8 Age Between 66-69	1
Nurse	**509**
1.2 Age Between 21-30	23
1.3 Age Between 31-40	48
1.4 Age Between 41-50	36
1.5 Age Between 51-55	44
1.6 Age Between 56-60	143
1.7 Age Between 61-65	146
1.8 Age Between 66-69	67
1.9 Age 70+	2
Nurse; Midwife	**3**
1.6 Age Between 56-60	2
1.8 Age Between 66-69	1

Opt-outs

Row Labels	Count of Emergency Register ID
England	849
N Ireland	29
Scotland	82
Wales	55
Not Given	3
Grand Total	**1018**

Overseas cohort

Part of the register	Total Registrants
Midwife	3
Nurse	1619
(blank)	3
Grand Total	**1625**

Country of address	Total Registrant
England	1510
N Ireland	26
Scotland	18
Wales	39
Not Given	32
Grand Total	**1625**

Wales	**39**
Nurse	**39**
1.2 Age Between 21-30	19
1.3 Age Between 31-40	17
1.4 Age Between 41-50	2
1.5 Age Between 51-55	1

140. Any issues relating to registrants progressing through the process such as delays in deployment, processing pre-employment checks or delivering training, would have been addressed by the employing Local Health Board or Trust, with assistance from the Workforce and Organisational Development Directorate.

141. Another important issue on which we engaged with the NMC was the use of the workforce risk assessment tool. I was keen to ensure that whenever the NMC issued joint statements or engaged with employers or Unions that the use of the risk assessment tool was highlighted for all staff and in particular that the disproportionate impact of Covid-19 on certain groups of people was considered. I exhibit as **M3CNOW01/053 - INQ000412538,** an email chain which includes discussion of the risk assessment tool being included in correspondence.

Gareth Howells

142. I met with the Chief Registrar or their nominated deputy regularly in monthly one-to-one meetings and on an ad hoc basis, depending upon emerging professional and regulatory issues or risks.

Sue Tranka

143. The NMC Chair and the Chief Registrar meet with the Minister for Health and Social Services bi-annually and I attend as the official responsible for supporting the Minister in these discussions. The meetings that took place during the relevant period in my time in post are 8 December 2021 and 27 June 2022.

144. I also meet with the Chief Registrar or their nominated deputy regularly in monthly one to one meetings and on an ad hoc basis, depending upon emerging professional and regulatory issues or risks.

145. Throughout the later state of the pandemic, when I took up the post of CNO in Wales I started to meet and correspond with the NMC on a variety of issues including workforce, registration standards, regulatory progress and advanced practice. These meetings occur through a monthly four nation CNO and NMC meeting and includes a country specific update provided by the CNO or designated deputy.

146. Wales continues to have a strong professional relationship with the NMC and we work closely with the designated professional lead at the NMC for Wales which is currently Sam Foster (Executive Director of Professional Practice).

Welsh Nursing and Midwifery Committee

Jean White, Gareth Howells and Sue Tranka

147. The Welsh Nursing and Midwifery Committee provides a forum to discuss professional nursing and midwifery issues. This was one of several statutory health professional committees advising the Welsh Government. The chairs of these committees attended the National Joint Advisory Committee, normally chaired by the

CMO(W). The chairs also met with the Minister for Health and Social Service annually. The Welsh Nursing and Midwifery Committee had a membership of 19 mostly frontline staff and educators, and it met on a quarterly basis. Exhibit **M3CNOW01/054–INQ000300072** sets out the committee's terms of reference.

148. As outlined in the terms of reference, the Welsh Nursing and Midwifery Committee provides advice to the CNO(W) and through the CNO to Welsh Government officials and Ministers on all matters relating to the nursing and midwifery professions. The CNO normally delegates representation from the office to this committee. Nursing Officer **Name Redacted** is the invited representative to the Committee and provides updates on behalf of the Chief Nursing Officer. The terms of reference are reviewed periodically, and when the Chair changes.

Jean White

149. In the initial period of the pandemic in 2020, the Welsh Nursing and Midwifery Committee meetings were paused to allow the representatives to focus all their time on operational matters. During the hiatus in the meetings, I continued to receive feedback from the Executives Nurse Directors and via the various service specific expert groups, as referenced above, who were continuing to meet virtually to address service delivery challenges. This ensured I continued to have professional nursing and midwifery matters brought to my attention. The first meeting held in the calendar year of 2020 was on 7 September, and I produce here as exhibit **M3CNOW01/055–INQ000300073** the minutes of that meeting. I was unable to attend this meeting and that **Name Redacted** attended as my representative. This meeting provided an opportunity to reflect on what had happened during the pandemic to date and consider what lessons could be drawn from members' experiences. At the meeting, members noted the improvements in digital capabilities, guidance, and sharing good practices across Local Health Boards, though members discussed concerns about patients who may be unable to access digital services, and particularly patients who had dementia or mental health problems who still needed to have face-to-face contact. The Committee also discussed the importance of social distancing not only

for nurses in the workplace but also in their daily lives, and how to further encourage this. The third area discussed was in relation to managing the new intake of student nurses in their clinical placements, made more difficult by the limitation on face-to-face contact with patients, and the larger numbers of students recruited to the September intake. It was noted that there had been good working relationships between NHS Wales providers and the Higher Education Institutions to manage the situation.

150. Regular meetings resumed at this point and a Nursing Officer from the Office of the CNO(W) was present. Nurses and midwives played a critical role in responding to the pandemic, and the committee worked to support them in their efforts. The committee provided guidance and support to nurses and midwives on issues such as infection prevention and control, personal protective equipment, and the management of patients with Covid-19. The committee also worked to ensure that nurses and midwives were able to continue to provide safe and effective care to patients, despite the challenges posed by the pandemic.

151. Example sets of minutes of meetings dated 7 September 2020, 20 May 2021, and 15 March 2022 are exhibited as previously exhibited in **M3CNOW01/055 - INQ000300073,** as exhibited here in **M3CNOW01/057 - INQ000412565,** and **M3CNOW01/058 - INQ000412569** respectively.

Sue Tranka

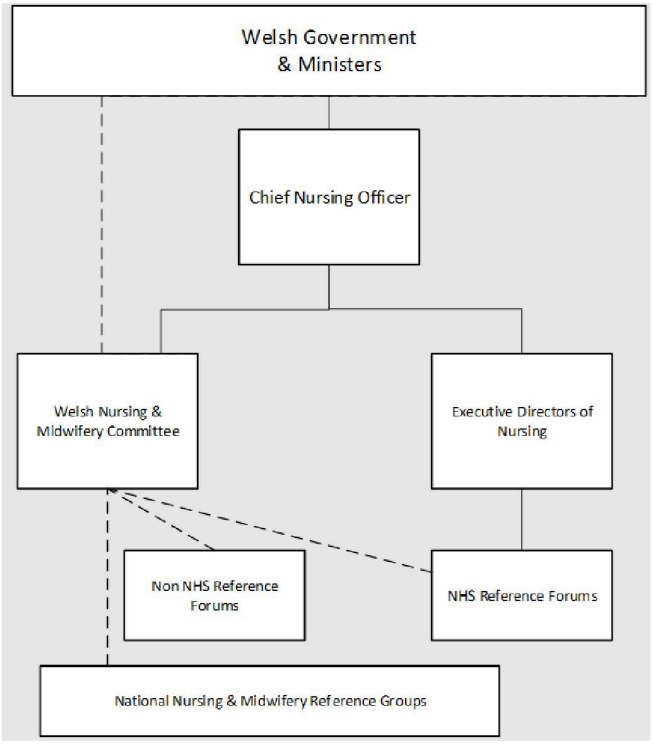
152. The Welsh Nursing and Midwifery Committee re-established itself in 2022 with regular meetings and a newly appointed chair. The committee seeks to ensure that it works effectively and responds to the national priorities of the CNO(W) and provides advice to the Minister on matters related to nursing and midwifery.

153. I attend the meetings regularly to provide a CNO(W) update and offer time for questions and concerns to be raised. **NR** and **NR** are invited members of the committee and regularly provide updates on my behalf.

154. The Welsh Nursing and Midwifery Committee provide updates to the CNO(W) from all membership groups represented and formally raise matters of concern for the profession that require the attention of the Welsh Government. No queries were raised with me by the Welsh Nursing and Midwifery Committee during the relevant period from August 2021. There were no known gaps in the provision of information to the CNO(W) office during this period as this is not an operational group that the CNO depends on for decision making. Their role is focused on advising on nursing and midwifery professional issues and during the relevant period issues related to the above were picked up by Nurse Directors in our regular meetings.

155. This is an active and effective group and one which is highly valued within the Welsh NHS and the Office of the CNO(W).

156. I have reproduced below a chart representing the Welsh Nursing and Midwifery Committee governance and reporting.



Heads of Midwifery Advisory Group

Jean White, Gareth Howells and Sue Tranka

157. The All-Wales Heads of Midwifery Advisory Group is a forum which facilitates collaborative working and communication between the leaders of midwifery and maternity services across Wales and is directly accountable to me as the Chief Nursing Officer for Wales. Throughout the relevant period the group met regularly and was supported by, and the meetings led by, NR

Jean White

158. The All-Wales Heads of Midwifery Advisory Group predates the Covid-19 pandemic and is one of the many professional/clinical area specific groups established to provide clinical expert advice to the CNO(W) and Welsh Government. I often used these predominantly operational-focused meetings to discuss how Welsh Government policy could be enacted 'on the ground'. An example from the pre-pandemic period was the development of midwife-led units across NHS Wales and introduction of the PROMPT multiprofessional obstetric emergency training. The meetings were a place to work through practical implications of change and an excellent means to have grass roots feedback to me and my team. An example of this during the pandemic was the development of hospital visiting guidance for antenatal screening appointments, the provision of support to the labouring woman and visiting in the postpartum period (discussed in further in paragraphs 338-349). NR attended the meetings and I usually attended once a year just to touch base personally with the midwives.

Gareth Howells

159. The All-Wales Heads of Midwifery Advisory was not a meeting I attended, but I received feedback by exception from NR

Sue Tranka

160. The All-Wales Heads of Midwifery Advisory Group is a meeting regularly attended by the Chief Midwifery officer on my behalf, and I receive feedback by exception only. Accordingly, I did not attend regularly but as CNO(W) have on occasion been invited to provide updates and share policy intentions, emerging concerns from the profession, and insights are shared from service which may require the attention of the Welsh Government.

Royal College of Nursing Wales ("RCN")

Jean White, Gareth Howells and Sue Tranka

161. The Royal College of Nursing is an important stakeholder with whom the Welsh Government works closely. It is the main nursing union and professional body in the UK. Meetings take place on a quarterly basis between the Minister for Health and Social Services and the Wales Director of the Royal College of Nursing. We attended these meetings, or a Nursing Officer attended on our behalf, to support the Minister from both an official and professional capacity. The discussions focus on professional nursing matters relating to Wales.

Jean White, Gareth Howells and Sue Tranka

162. The Royal College of Nursing Wales met quarterly with the Chief Executive of the NHS. The CNO, or a Nursing Officer on our behalf, would attend to support the discussions.

163. The CNO met with the Royal College of Nursing Wales Director on a quarterly basis for a regular professional update, where we discussed matters related to workforce recruitment and retention, regulation and education. Generally, the Director aimed to inform me of emerging guidance from the Royal College of Nursing.

164. The RCN Director is also invited twice yearly and on an ad hoc basis to the Health Boards/Trust Nurse Director forums, to attend the joint CNO and Nurse Director meetings.

Royal College of Midwives ("RCM")

Jean White, Gareth Howells and Sue Tranka

165. The Royal College of Midwives is the only professional organisation and trade union dedicated to serving midwifery and the whole midwifery team so is an important stakeholder who the Welsh Government engages with. Meetings take place on a quarterly basis between the Minister for Health and Social Services and the Director of the Royal College of Midwives. During the relevant period, I attended these meetings, or a Nursing Officer attended on my behalf, to support the Minister from a professional capacity. The discussions focus on professional midwifery matters relating to Wales.

166. The Royal College of Midwives Wales Director also met with the CNO and NR NR on a quarterly basis for a regular professional update, to discuss matters related to midwifery workforce, safety, and education.

Health and Social Care Professions Council ("HCPC").

Jean White

167. The CNOs had little direct contact with the HCPC throughout the pandemic. However, I was aware of their campaign to bring health professionals back into the workforce (similar to that of the NMC) and indeed was involved in the Welsh 'drive' to support the regulators position - recording a short video clip to provide further information for recently retired workers who may wish to return to work.

168. The Office of the CNO shared guidance at the Primary & Community Covid-19 Subgroup which included a HCPC joint statement about how they would be regulating Allied Health Professions during the pandemic. The HCPC worked across

all 4 nations to ensure that registrants could return to the HCPC register in order to extend the workforce and we supported this.

Gareth Howells

169. I had no direct contact with the HCPC but I was aware of their campaign to bring health professionals back into the workforce.

Sue Tranka

170. I have no direct contact with the Health and Social Care Professions Council but I aim to keep abreast of their work and its potential for impact or alignment with the nursing and midwifery profession.

Working with the Chief Nursing Officers of England, Scotland and Northern Ireland

Jean White

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

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

173. I produce here, as exhibit **M3CNOW01/059–INQ000300129**, the draft terms of reference for the UK CNO meetings, as re-drafted on 6 October 2020. These were agreed without amendment on the 19 October 2020 as noted in **M3CNOW01/059a–INQ000300134.** As outlined in the terms of reference, the meetings are a peer forum

to support knowledge sharing and alignment on nursing and midwifery professional matters, and to support the response to Covid-19.

174. We occasionally contacted each other for specific things. For example, the CNO(NI) contacted me on 13 October 2020 seeking mutual aid in the form of qualified nurses to come and work in the NHS NI to help with their upsurge in Covid 19 cases. As described in paragraph 103.b of this statement, this request was declined following my advice to the Minister for Health and Social Services, for the reasons set out in that paragraph. The CNO(NI)'s request and my response were previously exhibited at **M3CNOW01/033–INQ000299602** and **M3CNOW01/034-INQ000299603** respectively.

175. I contacted the CNO(E) in November 2020 to discuss guidance on nurse-to-patient ratios in intensive care. As described in greater detail in paragraph 103.c of this statement, this discussion resulted in my advising the Minister for Health and Social Services that we follow the same advice as NHS England.

176. I recall that I took part in a virtual discussion on requiring the public to wear face coverings when accessing healthcare settings with the UK CNOs. I do not recall the date of this but believe this would have been between July and September 2020. This discussion took place at the request CNO(E) because she had been asked to develop a policy position for NHS E. At that time, the CMO(W) had been urging caution about the use of public using face coverings generally because of the concern of inappropriate use by members of the public i.e., not adequately covering the nose and mouth, face touching leading to cross infection, making communication more difficult for patients who lip read, being seen as a barrier when dealing with children and young people. There were also concerns about stock availability. I fed back the discussion to the CMO(W) to feed into the advice he was preparing for Ministers. I understand that the outcome was that Wales was slower in adopting a policy mandating the public to wear face coverings in health care settings, although I was not directly involved in that decision.

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

Gareth Howells

178. In my experience, the relationships between the four nations were eminently positive. From a nursing perspective, there were regular peer support meetings between the Chief Nursing Officers in Wales, England, Scotland, Northern Ireland and the Republic of Ireland. These acted an informal forum to provide and share support, advice, and concerns, as well as best practice.

179. At the 14 May 2021 meeting, the Chief Nursing Officer for England, Ruth May, highlighted concerns regarding the spread of a new Covid-19 variant of Indian origin (later named the Delta variant) across the regions.

180. I also attended meetings of the UK Senior Clinicians Group, chaired by the Chief Medical Officer for England. This group shared the latest scientific advances to help understanding and ensure a consistent UK approach across devolved administrations, where possible. I understand that minutes of these meetings were kept by the Chief Medical Officer for England.

181. I do not recollect any specific occasions when a divergent approach was taken in Wales during my tenure as Interim Chief Nursing Officer for Wales, and I would be surprised if this was the case as the public health advice was largely consistent on the areas within my remit as ICNO(W), i.e., nursing and midwifery profession and practice.

Sue Tranka

182. Prior to taking up post as the Chief Nursing Officer for Wales, I had been invited intermittently to the UK Chief Nursing Officer meetings in my capacity as Deputy

Chief Nursing Officer for England to update the Chief Nursing Officers on matters within my portfolio, i.e., infection prevention and control guidance, development of the national infection prevention and control support programme, behavioural change programme for infection prevent and control compliance, and hospital visiting. I am unable to comment on whether these structures changed during the period prior to my appointment as Chief Nursing Officer for Wales as I was not closely enough involved in those structures as Deputy Chief Nursing Officer for England.

183. In my opinion, the current relationship between the four Chief Nursing Officers across the UK is a strong, professional, and supportive relationship. The Chief Nursing Officers from Wales, Scotland and Northern Ireland were all appointed relatively recently and at around the same time; the Chief Nursing Officer for Scotland took up post in October 2021, shortly after I took up post as Chief Nursing Officer for Wales, and the Chief Nursing Officer for Northern Ireland took up post in March 2022. This makes us a fairly new team, and we have all benefited from the mutual professional support that this team have offered to one another.

184. We have a standing fortnightly professional meeting (called the Chief Nursing Officers Forum), with nominated deputies who attend with us and deputise as necessary. This is a formal meeting relating to nursing professional matters. These meetings have touched on the pandemic response across the UK, for example following receipt of evidence reviews or technical updates from the UK IP&C Cell or the UK Health Security Agency. All Chief Nursing Officers share a relevant country specific update relating to Nosocomial infections, infection prevention and control guidance considerations, staff sickness from Covid-19, so mainly operational challenges as a result of the ongoing pandemic phases. These meetings also act as a forum for agreeing decisions and actions in respect of professional nursing approaches across all four countries that are wider than the pandemic, for example, discussions recently have addressed industrial action readiness.

185. The four Chief Nursing Officers do not have a WhatsApp group between us, that I have been invited to join nor participated in, during my time working at the Welsh

Government as the Chief Nursing Officer for Wales. The Chief Nursing Officer for health England and I remain in contact via private messages exchanged over WhatsApp and iPhone messaging.

186. I can confirm that my WhatsApp messages that I exchanged with the Chief Nursing Officer for England during my time since in post at the Welsh Government up to 30 May 2022 have been disclosed to the Inquiry.

187. I only attended a few of the joint UK Chief Nursing Officer or Chief Medical Officer meetings after taking up post of Chief Nursing Officer for Wales in August 2021 and I understand the Group was stepped down by the Chair Sir Chris Whitty in March / April 2022. Copies of actions were shared ahead of meetings as part of the meeting papers, by the Secretariat, in the Chief Medical Officer for England's office.

Involvement in the formulation of guidance relating to nursing or other healthcare-related issues during the relevant period

Jean White

188. As described in paragraph 73 of this statement, nursing officer **Name Redacted** supported the First Minister's Black, Asian and Minority Ethic Covid-19 Advisory Group which was established on 29 April 2020 and which issued guidance and the Covid-19 workforce risk assessment tool (previously exhibited in **M3CNOW01/013–INQ000299409**) shortly thereafter.

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

190. Details of my involvement in the formulation of guidance through my role on the Nosocomial Transmission Group is set out later in this statement.

Staffing ratios

191. One of the challenges the NHS faced was in expanding its critical care services to meet the increased demands of very sick patients due to the Covid-19 pandemic. Expansion required more equipment, such as ventilators and Continuous Positive Air Pressure (CPAP) machines (CPAP work by pressurising the air that is delivered through a hose and mask. The steady flow of air keeps the airway open and improves respiration), and crucially more staff. However, it was not just a simple matter of deploying staff from another area to work in the intensive care and high dependency units due to the specialist highly technical nature of the work. Normal pre-pandemic practice in intensive care was for one trained critical care nurse per level 3 patient with additional senior nurse oversight of the unit; and one critical care trained nurse for two level 2 patients again with senior nurse oversight in the unit. Level 3 intensive care units take critically ill patients requiring mechanical ventilation, advanced monitoring, and specialised physician and nursing care. Level 2 intensive care unit patients require close cardiac monitoring and nursing observation. Decisions were therefore needed to determine the degree to which the critical care trained nurse to patient ratio could be increased safely, with the involvement of other redeployed staff.

192. A joint statement was made on 25 March 2020 by the UK CNOs, trades unions, and the following professional groups: UK Critical Care Nursing Alliance, CC3N British Association of Critical Care Nurses Intensive Care Society, RCN Critical Care Forum, and National Outreach Forum. This statement explained our collective view on the need for a different way of staffing critical care settings and the need for a team-based approach to be introduced. I produce here, as exhibit **M3CNOW01/060–INQ000227427** that joint statement. I shared the guidance that emerged from the expert clinical group - The UK Critical Care Nursing Alliance – that provided options for changes in staffing ratios with Welsh Government policy lead that dealt with the Wales Critical Care and Trauma Network. This network considered this guidance and applied what they considered appropriate for NHS Wales' critical care settings. I believe the result of this was to allow some changes to the staff patient ratios in the intensive care units across Wales. I recall being told that during the height of demand

one intensive care nurse was overseeing the care of two level 3 patients with the support of another health professional. I think the maximum number of level 3 patients any trained intensive care nurse could be asked to look after was three, with other health professionals in a supporting role, but that this ratio was not routinely required. I also shared the information with the Nurse Directors, to draw their attention to the position being advocated to help them with local decision making on staffing. I further shared updates from the UK Critical Care Nursing Alliance when published in November 2020 and January 2021 with the same individuals.

193. Field hospitals in Wales were open and utilised consistently from October 2020 and I have provided an overview of the staffing model adopted for field hospitals in Wales in paragraph 85 of this statement.

Moral and ethical decision making

194. On 12 April 2020, the Chief Medical Officer and I issued a joint letter to NHS Wales informing them of the publication of a new framework of values and principles for healthcare delivery in Wales, to provide guidance for healthcare services when making decisions during the coronavirus outbreak that arose from the work of this group. I produce here a copy of my letter with the CMO, as exhibit **M3CNOW01/061–INQ000300105** and a copy of the framework, as exhibit **M3CNOW01/062–INQ000081000.** The framework outlines: core values to inform planning and decision making for health care delivery for people in Wales; using the framework to deliver health services; and principles and law underpinning ethical delivery of health care.

195. The CMO(W) and I issued further guidance on 17 April 2020 reminding clinicians that Do Not Attempt Cardiopulmonary Resuscitate ("DNACPR") decisions must be made on an individual basis. Age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes. I produce here, as exhibit **M3CNOW01/063–INQ000300106**, a copy of that letter.

Risk to people living in supported accommodation

196. I had a meeting with the Deputy Minister for Social Care on 15 July 2020 where she asked about testing vulnerable people who lived in supportive living accommodation, as there was now clear evidence of a higher risk of death from Covid-19 amongst this population than the general population. The Deputy Minister had reviewed the draft testing strategy for Wales (which I produce here as exhibit **M3CNOW01/064– INQ000275673** on 14 July 2020, in ministerial briefing MA/VG/2299/20 (which I produce here as exhibit **M3CNOW01/065– INQ000336847**), and she felt that the issue was not sufficiently clearly addressed. Following the meeting I spoke with the policy lead, Jo-Anne Daniels, and the outcome was an addition to section 5 in the new testing strategy (published later that week) that explicitly referred to people in supportive living accommodation. I produce here, as exhibit **M3CNOW01/066– INQ000300110**, a copy of the final testing strategy that was published on 15 July 2020.

Gareth Howells

197. Guidance prepared by the Nosocomial Transmission Group was distributed directly to the chief executives of local health boards, NHS trusts, social services departments in local authorities, and other relevant authorities, usually by one or other, or both, of the Group's co-chairs. I am not aware of any occasions when the advice of the Nosocomial Transmission group was not followed.

198. I would also discuss any new guidance, or updates to existing guidance, at my regular meetings with the executive nurse directors in the local health boards and NHS trusts in Wales. These meetings provided an important forum for sharing experiences, providing peer support, and ensuring a joined-up approach to nursing and midwifery leadership across Wales. I produce here, as exhibit **M3CNOW01/067– INQ000271913**, the terms of reference for these meetings, entitled "Health Board / Trust Nurse Directors Forum Terms of Reference". The terms of reference outline the purpose and functions of the forum, which include: ensuring nursing and midwifery moves forward in a consistent way across Wales; sharing and taking responsibility for professional issues related to nursing and midwifery education and

practice; commissioning of work to support the activity of the forum; and intelligence gathering and sharing good practice.

199. Appropriate policies and guidance were already in place when I took up post, having been developed by my predecessor, Professor Jean White, acting in conjunction with the Chief Medical Officer, Deputy Chief Medical Officer and Public Health Wales and, as the public health situation was broadly stable, there was no immediate requirement to revise or amend that extant guidance.

Sue Tranka

200. The purpose of the Nosocomial Transmission Group was to provide advice, guidance and leadership for all healthcare and care settings in Wales on the actions needed to minimise nosocomial infection and enable the safe resumption of services. This included hospitals, primary and community care settings, registered care homes, domiciliary care, learning disability units, and prisons. The work of the Nosocomial Transmission Group is described in more detail later in this statement.

201. In December 2021 I, along with the other three Chief Nursing Officers, raised concerns about the UK IP&C Cell guidance in light of the Omicron variant. We commissioned the UK IP&C Cell to undertake a review of the evidence and guidance to provide a view on whether the guidance needed to be enhanced given the emerging variants, respiratory and winter virus and increased staff absences. In particular, we sought the IPC Cell's view on whether there was a need to consider universal enhanced respiratory protection in healthcare settings, and any reasons why we should not take a precautionary approach with FFP2 masks for all staff, except where aerosol generating procedures were undertaken. A copy of my email to Dr Eleri Davies, Chair of the UK IP&C Cell, and her response is exhibited in **M3CNOW01/068- INQ000227346**. Her response advised that:

    a. "With regard to the wider use of respiratory protective equipment, there is already provision within the guidance for individual Trusts / Health Boards / Hospitals to undertake risk assessments and extend the use of RPE

[respiratory protective equipment] if risk assessments indicate that this is necessary – the guidance states: 'where an unacceptable risk of transmission remains following the hierarchy of controls risk assessment, it may be necessary to consider the use of RPE for patient care in specific situations when managing respiratory infectious agents. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area.'"

b. "We do not recommend wholesale use of FFP3 masks as they need to be fit-tested and used correctly, with training provided on donning and doffing. Each individual must have been fit-tested on the specific type of FFP3 mask available to them and if supplies change then individuals have to be fit-tested again on the new type of mask – these are HSE [Health and Safety Executive] requirements. HSE also require fit testing for FFP2 masks and advise against the use of FFP2 unless we are in contingency measures as these provide a lesser filtration rate than FFP3."

Awareness of any issues with national or local guidance for nursing staff and healthcare workers

Jean White, Gareth Howells and Sue Tranka

202. We have been asked to provide details of any issues with national and/or local guidance for nursing staff of which the CNO was aware during the relevant period. In considering this question we have considered the Nurse Directors meeting minutes from our respective tenures.

Jean White

203. The issues I am aware of relate to the impact of delay in guidance, a concern regarding insufficient consultation and issues regarding the implementation of guidance. The frequency of updates of guidance was not an issue because on the

whole this usually followed discussion with NHS and social care staff who were asking for more guidance.

Concerns about delay of guidance

204. As regards the impact of delay in guidance, at a meeting of the Nurse Directors on 31 March 2020, the Nurse Directors raised concerns regarding a delay in the publication of Public Health England guidance on dealing with deaths. It was agreed that guidance for Wales may need to be produced if the delays continued, and that I would circulate the guidance from Public Health England once it became available. I exhibit a copy of the minutes from the meeting of 31 March 2020 at exhibit **M3CNOW01/069** - **INQ000412476** Guidance produced by Public Health England and reviewed by the Nosocomial Transmission Group was subsequently issued by the Welsh Government on 14 May 2020, as described and exhibited in paragraph 320.a of this statement.

Concerns in respect of antenatal screening guidance

205. Hospital visiting guidance issued to commence on 20 July 2020 set out specific considerations for pregnant women and their partners visiting maternity services, including the antenatal scans and checks done at: 12 weeks pregnancy dating scan, early pregnancy clinic, anomaly scan, and attendance at a Fetal Medicine Department. The guidance, exhibited in **M3CNOW01/069a - INQ000299514** and described in further detail from paragraph 404 of this statement, had been developed following multiple correspondences from the public and Members of the Senedd, on behalf of their constituents, strongly requesting that partners should be present with the pregnant woman. After this guidance was issued, I received feedback from the sonographers and radiographers, who undertake the antenatal scans, raising concerns about the practical application of this guidance to their physical environments. Their concerns were that the rooms used for scans are typically small with limited ventilation, and consequently maintaining 2 metres distance from anyone accompanying the pregnant woman would be impossible. Additionally, waiting rooms could easily become full if additional people attended with the pregnant woman,

again making social distancing difficult. They also did not feel they had been consulted sufficiently before this new guidance was issued. I held a meeting with representatives on 5 August 2020 to agree a way forward, and I produce here the minutes of this meeting as exhibit **M3CNO01/070–INQ000300098**. It was agreed that a risk-based approach would be applied locally in order to ensure everyone's safety. I have provided more detail in relation to hospital visiting guidance later in this statement.

Concerns regarding the implementation of PPE Guidance

206. At a meeting of the Nurse Directors on 3 April 2020, it was noted that Public Health England had issued national guidance on the PPE outlining details of what items are to be worn in different settings and circumstances. I was informed by the Directors of Nursing that the national PPE guidance and UK resuscitation guidance had conflicting positions regarding whether CPR and chest compressions are considered to be an aerosol generating procedure ('AGP'). The relevance of categorisation as an aerosol generating procedure is that this would mean that full protective equipment should be worn, an FF3P respirator, eye protection and gloves. If not considered an aerosol generating procedure then chest compressions could be done without donning additional PPE. I agreed to raise this issue with policy colleagues on behalf of the Directors of Nursing. I exhibit a copy of the minutes from the meeting of 3 April 2020 at **M3CNOW01/071 -INQ000412477**.

207. At the following meeting of the Directors of Nursing on 7 April 2020, I informed the Directors of Nursing that the issue had been raised with NERVTAG to consider the evidence as to whether chest compression is an aerosol generating procedure and I advised that the current policy is to adopt the view set out in the national PPE guidance, albeit I accepted that in practice variation can and is happening. The variation in practice being observed in hospital settings (sometimes even within the same clinical setting by different professionals) was that some health care staff would only start chest compression when wearing aerosol generating procedure protective clothing, while other healthcare staff were not donning additional PPE. The details in

respect of the extent of this variance in practice was not reported to me, only that this was a professional issue that needed clarification in national guidance. The Directors of Nursing continued to have concerns on adopting a nursing-only approach and I agreed to feedback their position to the CMO. I exhibit the minutes of the meeting of 7 April at **M3CNOW01/72 -INQ000412487**.

208. On 14 April 2020, in view of the conflicting position on whether chest compressions were an aerosol generating procedure, the CMO and I issued a joint letter to the Directors of Nursing, and I exhibit a copy of that letter at **M3CNOW01/73 - INQ000412552**. The letter advised that:

a. A risk-based approach should be taken when undertaking resuscitation procedures, balancing the safety of staff and the likely best outcome for the patient. In some circumstances, not commencing resuscitation may be the right course of action, but not starting resuscitation procedures which may be beneficial to the patient, due to delays in accessing the equipment, must also be mitigated against as far as possible

b. First responders (in any acute hospital setting wearing locally/nationally agreed minimum level of PPE) can commence chest compressions and defibrillation, without the need for aerosol generating procedure PPE, while awaiting the arrival of other clinicians to undertake airway manoeuvres; and that the patient's mouth be covered when undertaking chest compressions.

c. A 'grab bag' containing aerosol generating procedure PPE should be placed on resuscitation trolleys to improve accessibility to equipment by staff.

d. The recently updated DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) guidance (described at paragraph 367 of this statement) should be referred to.

209. On 24 April 2020, the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") published its review on whether doing chest compressions and

defibrillation constituted an aerosol generating procedure (APG), which I produce here as exhibit **M3CNOW01/73a–INQ000257933**[1]. NERVTAG concluded it did not pose a significant risk and advised that when developing clinical policy about what personal protective equipment staff should wear, to bear in mind the time it takes to don said equipment and the impact this may have on the likely success of the resuscitation.

210. At the Nurse Director meeting on 24 April 2020, I informed the Nursing Directors that NERVTAG had concluded that chest compressions do not provide sufficient risk from infection to be classed as aerosol generating procedure and as a result the UK guidance on appropriate use of PPE had not changed. I exhibit a copy of the minutes for that meeting at **M3CNOW01/74-INQ000412508**.

211. On 28 April 2020, the Resuscitation Council UK provided guidance (which I produce here as exhibit **M3CNOW01/074a– INQ000251651**[2]) that indicated that only chest compressions should be undertaken and that the collapsed persons mouth and nose should be covered by a cloth, because there was a potential of aerosol generation that would spread the virus. There appeared to be conflicts in the guidance produced by NERVTAG, and the Resuscitation Council UK guidance. The British Medical Association and the Royal College of Nursing challenged the assertions made by NERVTAG in respect of the potential level of risk to staff. Consequently, I observed in Wales differing approaches to clinical policies in the health boards and NHS trusts. Local Health Boards and NHS Trusts were deciding for themselves whether to instruct staff to treat CPR as an aerosol generating procedure or not, and consequently what approach staff should take regarding PPE in this context. This meant that NHS Wales did not have a consistent approach on

---

[1] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000300118]*

[2] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000300119]*

this matter. This disagreement between bodies was escalated to the UK Senior Clinicians group, who decided that a new independent panel should be set up to look at high risk procedures such as chest compression in cardiopulmonary resuscitation, to determine the level of risk. It was called the Independent High Risk APG Panel. It was chaired by Professor Jacqui Reilly. The group held 11 meetings between 27 July 2020 and 12 April 2021. The CMO(W) and I issued a letter on 7 May 2020 to the medical and Nurse Directors entitled "Personal protective equipment (PPE) for CPR and resuscitation" to address how NHS Wales organisations should set local policy and the discretion afforded to staff on what PPE to wear. This guidance reminded staff that there should not be unnecessary delay in starting life-saving treatment. I produce the letter here as exhibit **M3CNO01/75–INQ000299272**.

Concerns regarding the implementation of the Nosocomial Guidance Bundle

212. The minutes of the Nurse Directors meeting on 13 November 2020 note that a concern was raised in relation to the nosocomial guidance bundle which contained the actions required around the management of putting things right where nosocomial transmission had or potentially caused harm, how this was to be logged, investigated and handled. It is my understanding that there were concerns around the guidance bundle being too onerous based on the staffing levels at that time during the pandemic and also that a draft of the guidance contradicted other guidance in relation to Covid-19 and the complaints processes used by the NHS (termed the "putting things right" process). Any action in relation to that guidance would have been undertaken by officials responsible for patient experience. I exhibit the minutes for the meeting of 13 November at **M3CNOW01/076- INQ000412576.**

Concerns regarding the NHS Wales National Framework – Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 guidance

213. At a meeting of the Nurse Directors on 19 March 2021, Directors of Nursing raised concerns regarding the implementation of the new 'NHS Wales National Framework – Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19' guidance in terms of its complexity and time-consuming nature of

identifying causes. I noted that this was NHS guidance coordinated through the NHS Wales Delivery Unit, and advised that this feedback should be provided to Melanie Harries, the Quality and Performance Improvement Manager at the Delivery Unit. I exhibit the minutes for the meeting of 19 March 2021 at **M3CNOW01/077-INQ000412585.**

Gareth Howells

214. I am not aware of any specific issues with national and/or local guidance for nursing staff and healthcare workers raised during my tenure as CNO.

Sue Tranka

215. Most of the guidance was extant by the time that I took up the role of CNO. I cannot recall any specific issues with national and/or local guidance for nursing staff and healthcare workers raised during my tenure as CNO other than an issue regarding the de-escalation of IPC guidance noted in a meeting of the Nurse Directors on 29 April 2022. In particular, issues were raised by the Chair of Directors of Nursing regarding the support available in the de-escalation procedure and the speed with which such changes would take effect. I advised that a letter confirming the de-escalation measures would be set out in a letter to the NHS. I exhibit a copy of that letter as exhibit **M3CNOW01/078-INQ000353329**. I also held a series of webinars with Dr Chris Jones with the aim of providing support to the NHS workforce on de-escalation measures, during which I took a number of questions from attendees to allay any concerns.

Involvement in decisions relating to the temporary register

Jean White

216. I joined the other UK Chief Nursing Officers, Ruth May, the Chief Nursing Officer for England, Fiona McQueen, the Chief Nursing Officer for Scotland, and Charlotte McArdle, the Chief Nursing Officer for Northern Ireland ("the UK CNOs"), to work with the Nursing and Midwifery Council to make changes to the education standards that

modified the training of pre-registration nursing and midwifery students and created a temporary register for specific groups of staff, including recently retired staff who wished to return to practise. The first such virtual meeting took place on 12 March 2020, and I produce here as exhibit **M3CNOW01/079– INQ000300131**, the minutes of that meeting. NR Midwifery Officer, Name Redacted and Name Redacted Nursing Officers were involved in the numerous meetings. Health Education and Improvement Wales ("HEIW"), which is the strategic workforce body for NHS Wales and commissions professional health education on behalf of Welsh Government, officers played a significant role in implementing the changes to standards via the Council of Deans Wales.

217. On 2 April 2020, I provide advice to the Minister in respect of an extension of the Covid-19 temporary register to overseas nurses and midwives who had completed all elements required for registration except the Objective Structured Clinical Examination (OSCE); and those who had left the register 4-5 years ago. A joint statement was issued with Ministerial approval. I produce here my advice to the Minister, as exhibit **M3CNOW01/080–INQ000226982**; the Minister's approval of that advice, as exhibit **M3CNOW01/081–INQ000299092**; and the joint statement, as exhibit **M3CNOW01/46 –INQ000300100,** entitled "Joint statement on expanding the nursing and midwifery workforce in the Covid-19 pandemic".

218. On 29 June 2020, the Minister for Health and Social Services published a written statement explaining that the three and six-month contracts given to student nurses and midwives which enabled payment for their clinical work during the pandemic would not be extended beyond the original time agreed for the contracts. The reason for not extending paid contracted work as healthcare support workers was that there were concerns that students would not have the opportunity to complete their programmes on time in order to enter the professional register and subsequent employment as a fully registered nurse. A copy of that written statement was previously exhibited at **M3CNOW01/031–INQ000300021**.

219. On 4 January 2021, the Minister for Health and Social Services was informed of the Nursing and Midwifery Council's intention to further extend the criteria for overseas trained nurses to join the Covid-19 temporary register, with effect from 6 January 2021. He agreed to their issuing a high-level statement. There were some overseas nurses (estimated 100-130) who would benefit from these changes. I produce here, as exhibit **M3CNOW01/047–INQ000300102**, a copy of that statement.

220. In relation to the Secretary of State's December 2020 decision not to expand temporary registration for midwives, the four nations' CNOs were in agreement that this was the right approach because the number of births was unaffected by the pandemic and the focus was on the more effective use of resources rather than a need for additional midwives. I also asked NR to discuss with the LHB heads of midwifery and my understanding was that there were not any calls for additional midwifery staff. Maternity services were classified as Essential Services during the pandemic thus ensuring that midwives were not deployed to other clinical areas. Staff capacity was also bolstered by the redeployment of registered midwives, who had been working elsewhere within the NHS, back into maternity services and the use of clinical placements of third year midwifery students.

Gareth Howells

221. I played no role in decisions relating to temporary registration as these arose prior to or after my tenure as CNO.

Sue Tranka

222. I had no involvement in the eligibility criteria for temporary registrations, how fitness to practise would be determined, the June 2020 changes to the eligibility criteria for applicants educated outside of the UK, or the UK Secretary of State for Health and Social Care's decision in December 2020 not to expand temporary registration for midwives as these matters predated my tenure as Chief Nursing Officer for Wales.

223. I was not involved in the decision on 21 February 2022 to end temporary registration effective from 30 September 2022. As Chief Nursing Officer for Wales I received

regular updates from the Nursing and Midwifery Council and appropriate action was taken to update the sector as set out in my email to the Minister for Health and Social Services on the 24 May 2022, exhibited in **M3CNOW01/084-INQ000412559,** in which I summarised that:

a. The NMC had informed all UK nations that they would stop accepting new people onto the Covid-19 temporary register from 24 March 2022. We had been aware of this for a while and all Health Boards and Trusts had been working with temporary registrants to help transition onto the permanent register.

b. We had confirmation in March from the NMC that the temporary register would close on 30 September 2022.

c. This confirmation meant that as at the 30 September 2022, temporary registrants would no longer be able to practise as a temporary registrant. The workforce was informed via a letter from the NMC that in order to continue practising after this date, arrangements to join the permanent register would need to be made. Those wanting to continue practising from 30 September 2022 could make arrangements to join the permanent register.

d. I had notified the Executive Directors of Nursing on the on 24 February 2022 that the NMC would not be accepting anyone new onto the temporary register from 24 March 2022 and that the temporary register will would end whilst also sharing the information to support joining the permanent register, we have been expecting this for some time.

224. I confirmed then, as I do now, that we were grateful to all those who retired and returned by joining the NMC temporary register to support our system response to the pandemic, our workforce continues to make a tremendous contribution to the health, social care and well-being of the population in Wales.

225. I was not involved in the subsequent decision on 22 September 2022 to reverse the arrangements as I had outlined to the Minister above or to retain temporary emergency registration until 2024. I was not aware that the NMC was not directly consulted on the plan to retain temporary emergency registration until 2024.

226. I was informed by the NMC on the 17 November 2022 that, following the Government's decision to keep the emergency temporary register open for a further two years, the NMC had carefully considered how they could continue to keep the temporary register open safely. The NMC confirmed that their approach to maintaining the NMC temporary register from January 2023, would be to:

    a. Retain people who left the permanent register less than three years ago: the NMC would make no change to this cohort, but would apply conditions of practice (outlined below) when it has been more than three years since they left our permanent register.

    b. Retain people who left the permanent register more than three years ago who are practising: this cohort would remain registered but with conditions of practice. This would include those who previously may have been working without conditions of practice because at the time they had been away from the permanent register for less than three years.

    c. Remove people who left the permanent register more than three years ago who are not practising: the NMC confirmed they would write to this cohort asking if they are practising, then remove them if they are not practising or do not reply.

    d. Overseas-trained registrants: those who are completing the final stages of their application for permanent registration will remain on the temporary register while they do so. We will remove those who are not actively progressing their application for permanent registration.

227. The NMC continued to apply conditions of practice to people who had either not yet met the registration requirements (i.e. overseas candidates) or left the permanent register more than three years ago, meaning:

    a. Temporary registrants would have to work as a registered nurse or midwife in an employed capacity for a health or social care employer.

    b. Temporary registrants must always work under the direction of an NMC registered nurse, midwife or other registered healthcare professional who is not on a temporary register.

228. Additionally, to ensure that people with temporary registration were keeping their knowledge and skills up to date, the NMC applied the following condition of practice requiring everyone on the temporary register to undertake appropriate training and continuing professional development (CPD) to practise safely and effectively in their role during the emergency. The NMC were clear that they would continue to expect employers to ensure temporarily registered nurses and midwives are deployed in roles that support the Covid-19 response and recovery. It also remained a requirement for nurses and midwives to hold appropriate indemnity or insurance cover for any work they do while on the temporary emergency register.

229. In terms of what this meant for the number of nurses and midwives on the temporary register in Wales, the NMC data showed that as of 30 September 2022 there were 639 people on the temporary register in Wales. 137 people left the main register less than three years ago and therefore were not immediately affected by the NMC's proposals. The NMC advised that 38 temporary registrants were practising and so would remain on the temporary register subject to the conditions outlined above. 450 temporary registrants informed the NMC that they were not practising and therefore would be removed from the temporary register.

230. I was informed by Linda Everet of the NMC on 18 January 2023 that plans to remove people from the temporary register were postponed until March 2023. The NMC

asked CNOs to confirm their support for this decision in writing, which I did on 23 January 2023.

Concerns raised regarding the temporary register

Jean White, Gareth Howells and Sue Tranka

231. We have been asked to provide details of any concerns brought to the attention of the CNO regarding nurses and/or midwives on the temporary register, for example, their deployment, and any regulatory issues. In considering this question we have considered the Nurse Directors meeting minutes from our respective tenures.

Jean White

Concerns regarding the deployment of staff over 60

232. At the Nurse Directors meeting on 10 April 2020, a concern was raised by Ruth Walker, Nursing Director at Cardiff and Vale University Health Board about the deployment of returning staff aged over 60, particularly given the number of older health workers who appeared to have been affected in Italy. I exhibit a copy of the minutes for the meeting on 10 April 2020 at **M3CNOW01/085 -INQ000412492**. At the 24 April 2020 meeting, Ruth Walker updated that Cardiff and Vale had opted not to deploy over 60s into Covid-19 areas and was reviewing staffing arrangements, noting that some staff were anxious about moving into different areas. She indicated she would share details with the other Directors of Nursing. I have provided further information regarding the concerns about older staff later in this statement.

Concerns regarding the registration of third year students

233. At the Nurse Directors meeting on 17 April 2020, it was noted that the Nursing Midwifery Council had been planning to open up the temporary register to third year student however concerns were expressed that the temporary registration of third year students may hinder their progress and delay entry onto the full register. I indicated that I would be discussing the possible expansion of the temporary register

to third year students with the Nursing and Midwifery Council and unions. I indicated my view, with which the Directors agreed, that third years may not need to be on the temporary register as we did not have the shortage of registered nurses in Wales as was being seen in England. I exhibit the minutes of the meeting on 17 April 2020 at **M3CNOW01/086-INQ000412495**. At the Nurse Directors meeting on 24 April 2020, it was noted that further discussions had arisen over whether to allow third year students to enter the full register early as some had completed all of their assignments and had undertaken sufficient clinical hours. However, I felt that we should not rush third years to register and should remain with the planned timescales in completing their respective university courses. I previously exhibit the minutes of the meeting on 24 April 2020 at **M3CNOW01/074-INQ000412508**. We ultimately agreed not to adopt the NMC Emergency Standards placing third year students in rostered paid employment, and my office received a large amount of correspondence from students asking why we had adopted this position. On 27 January 2021, I took part in a joint webinar with the Nursing and Midwifery Council for Welsh students, to address their questions. Q&As on this subject were also published on the Health Education and Improvement Wales website.

Concerns regarding the students' terms and conditions

234. At a meeting of the Nurse Directors on 28 April 2020, it was noted that the contracts for students to be deployed to the workforce were being coordinated by NHS Shared Services and in a meeting of the Nurse Directors on 1 May 2020 it was noted that there had been some issues with respect to the issuing of contracts, start dates and different health boards interpreting the contracts differently. The Welsh Government met with NHS Shared Services with a view to resolving the issues and, as noted in a meeting of 5 May 2020, Dr Andrew Goodall wrote to the Chief Executives of the Health Boards to clarify the terms and conditions around deployment of students. I exhibit the minutes of the meeting dated 28 April 2020 at **M3CNOW01/088-INQ000299245,** the minutes of the meeting dated 1 May 2020 at **M3CNOW01/089 - INQ000412509**, the minutes of the meeting dated 5 May 2020 at **M3CNOW01/090-INQ000299268**.

235. In November 2020, Health Education and Improvement Wales (HEIW) published a report entitled '"Smiling with your eyes": HEIW student survey summary report', exhibited at **M3CNOW01/090a –INQ000410913**[3]. Based on over 1000 responses from nursing and midwifery students deployed during the first phase of the pandemic, the results showed a high proportion of agreement with statements focused on students' sense of welcome and belongingness within the deployed area, their ability to work towards achievement of practice learning outcomes, opportunities for skill-development, perceptions of working within the limits of their competence, their coverage of induction and orientation to the practice setting, and access to an infrastructure of support. There were also qualitative survey responses, including from students reporting anxieties caused by the lack of clarity about contract arrangements. The report made recommendations for NHS bodies, including a review of measures in place to mitigate student anxieties should there be a reintroduction of deployment arrangements.

Concerns regarding the transition of students to registrants

236. At a meeting of the Nurse Directors on 20 November 2020, a concern was raised regarding the transition of nursing students to registrants. I indicated that additional guidance regarding professionalism was being developed on a four nations basis as part of the CNO and Royal College of Nursing foundation project. The guidance was subsequently published on the Nursing and Midwifery Council website, along with animations demonstrating aspects of professional behavior.

---

[3] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000474029]*

Gareth Howells and Sue Tranka

237. We are not aware of any concerns raised during our respective tenures in relation to the temporary register.

Involvement in the decision to introduce a set of emergency standards to allow student nurses to support the response of the healthcare systems to the Covid-19 pandemic

Jean White

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

239. The first meeting between the NMC, the UK CNOs, and other agencies took place on 12 March 2020. The minutes of that meeting were previously produced in this statement, as previously exhibited at **M3CNOW01/079– INQ000300131.**

240. On 21 March 2020, a joint statement by the CMO(W), the CNO(W) and the Deputy Director General of Social Services and Integration was prepared and issued, encouraging retirees (up to three years post leaving the professional registers) to return to help. This covered health and social care workers. I produce here a copy of this joint statement, entitled "Former and future health and social care professionals needed to help Wales respond to coronavirus" as exhibit **M3CNOW01/091– INQ000300044.**

241. On 23 March 2020, the Minister for Health and Social Services was asked to agree to the issuing of a joint statement by the NMC and UK CNOs on changes to the education standards for first, second, and third-years student nurses and midwives. A copy of the joint statement was exhibited earlier as **M3CNOW01/082–INQ000300100** and I produce here, as exhibit **M3CNOW01/093–INQ000299110**, a copy of my correspondence with the Minister regarding the statement.

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

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

    b. Students in the second year or the first six months of the final year of their undergraduate programme, and postgraduate pre-registration students not in the last 6 months of their programme, were advised that it was not possible to continue to provide the current programme. These students were invited to opt-in to an arrangement to spend 80 percent of their time in clinical practice, remunerated (band 3) (which would count towards their practice hours as it would form part of the student's programme), and 20 percent in academic study during this emergency period. The purpose of the period of academic study was to build in designated, structured, regular contact with their Approved Education Institutions (AEI). AEIs maintained academic and pastoral support throughout the programme, wherever the student was situated, during the emergency situation.

    c. Students in the last six months of their education programme could opt into an extended placement and undertake the final six months of their

programme as a clinical placement, remunerated at band 4. I produce here, as exhibit **M3CNOW01/094–INQ000300099**, a copy of this letter.

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

244. On 29 June 2020, the Minister for Health and Social Services published a written statement explaining that the three and six-month contracts given to student nurses and midwives which enabled payment for their clinical work during the pandemic would not be extended beyond the original time agreed for the contracts. The reason for not extending paid contracted work as healthcare support workers was that there were concerns that students would not have the opportunity to complete their programmes on time in order to enter the professional register and subsequent employment as a fully registered nurse. A copy of that written statement was previously exhibited at **M3CNOW01/031–INQ000300021**,

245. On 10 July 2020, the Minister for Health and Social Services was provided with an update on the nursing and midwifery programmes indicating that the NMC, with agreement from all four UK nations, would stop the emergency education standards introduced in the first wave of the pandemic on 30 September 2020. This briefing indicated that 90% of the 3rd year students would graduate on time with a maximum of delay for some students of up to 7 weeks. I produce, here as exhibit **M3CNOW01/095-INQ000300101**, a copy of that update.

246. As noted earlier in this statement, on 13 January 2021 I alerted the Minister for Health and Social Services to the letter sent by Matt Hancock, Secretary of State for Health to the Chief Executive of the Nursing and Midwifery Council requesting the reactivation of the emergency standards brought in during the first wave of the pandemic, and later withdrawn in summer 2020. If reactivated, it would enable 3rd

year nursing students to undertake a 12-week paid placement rather than have the normal supernumerary status that facilitated their clinical learning. My advice to the Minister was to note this request but that mobilising the 3rd year students in such a way was not deemed necessary for the delivery of care in Wales at that time. I reminded him that students who wished to undertake paid employment in NHS Wales on top of their studies were enabled to do so through the Nursing Bank system. The letter from the Secretary of State to the Chief Executive of the NMC and my advice to the Minister are exhibited earlier in this statement in **M3CNOW01/037–INQ000299755 and M3CNOW01/038–INQ000299754** respectively.

247. On 10 February 2021 a written statement was issued by the Minister for Health and Social Services in respect of not deploying 3rd year nursing students into rostered/paid employment. A briefing note was also sent to the Chair of the Senedd Health and Social Care Committee for noting, setting out the rationale for this decision. I produce here as exhibits **M3CNOW01/096–INQ000300104** and **M3CNOW01/097–INQ000299780** respectively, the written statement issued by the MHSS, and the briefing note provided to the Senedd Health and Social Care Committee.

248. The higher education programmes for nurses and midwives that prepared them for registration as Specialist Community Public Health Nurses (Registered SCPHN) and programmes that led to specialist community qualifications, such as district nurses, were temporarily paused to allow the deployment of staff to clinical areas. In the meeting with Nurse Directors on 5 May 2020, Stephen Griffiths, Director from Health Education and Improvement Wales, informed the Nurse Directors of the restarting of the programmes to enable staff to qualify either in 2020, or early 2021. The minutes of that meeting were previously exhibited at **M3CNOW01/090–INQ000299268**.

Gareth Howells and Sue Tranka

249. We had no involvement in the decision to introduce a set of emergency standards to allow student nurses to support the response of the healthcare systems to the Covid-19 pandemic.

Steps taken to increase the number of nurses and/or midwives in the healthcare system in Wales

Jean White

250. The initial plans prior to the first national lockdown on 23 March 2020 involved a series of steps, with the aim initially of trying to contain the spread of the virus once it had entered the UK/Wales, followed by plans to delay its spread and to prepare the system for cases. My primary concern at this point was on the nursing workforce. The signs were that there would be a rapid increase in cases once the infection gained a foothold in Wales and as a consequence, we would quickly need to increase the bed availability for infected patients, which would require relocating and retraining staff to work in areas unfamiliar to them, increase the number of staff able to give direct care, bearing in mind that staff too would become ill, and we would need to manage the impact of reduced supervision of students in training whilst on clinical placement. One of my early actions in this regard was to send a letter dated 24 March 2020 to the Nurse Directors explaining to them how to apply the Nurse Staffing Levels (Wales) Act 2016 to adult in-patient wards, which I produce as exhibit **M3CNOW01/098-INQ000474036** This had been agreed by the Minister for Health and Social Services, along with the revised timetable to extend the provisions of the Act to paediatric in-patient areas. I produce here, as exhibits **M3CNOW01/099–INQ000338217** and as previously exhibited at **M3CNOW01/026–INQ000299029**, my advice to the Minister for Health and Social Services on Covid-19 disruption to the Nurse Staffing (Wales) Act (MA/VG/0994/20) and the Minister's response to that advice.

251. I used the regular meetings with the Nurse Directors to monitor how the Nurse Staffing Levels (Wales) Act was being implemented as there was no relaxation of reporting compliance during the pandemic. Minutes of the meeting held on 12 May 2020 illustrates this and I produce these here, as exhibit **M3CNOW01/100-INQ000299276**.

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

253. I made a joint statement on 25 March 2020 with the UK CNOs, trades unions and professional groups explaining our collective view on the need for a different way of staffing critical care settings and the need for a team-based approach to be introduced. That joint statement, previously exhibited at **M3CNOW01/060–INQ000227427,** and the resulting actions are described in more detail at paragraph 192 of this statement.

254. Notwithstanding the actions outlined above to increase staff capacity, there were at times issues that were brought to my attention that there were not enough trained nurses to meet demand. I have considered the minutes of the Nurse Director meetings during my tenure and I have set out these concerns below.

Concerns regarding staff ratios

255. In early April 2020, I was made aware of concerns from the Critical Care Network about critical care nursing ratios extending beyond 1 critical care nurse to 3 patients in the guidance, about the level of expertise in critical care nurses in Wales and the plans for surge capacity. I discussed these concerns with Directors of Nursing at meetings on 3 April 2020 and 7 April 2020 and advised that the guidance offered various models to be introduced in a phased way, and that it provided for a 1:6 ratio only in extreme circumstances. The Directors of Nursing did not agree with the Critical Care Network's concerns and did not recognise any issues with the expertise in the workforce. They shared examples of how the team-based approach to expand the workforce was being used locally. The minutes of the meetings were previously

exhibited in this statement 3 April 2020 at **M3CNOW01/071-INQ000412477** and 7 April 2020 as previously exhibited at **M3CNOW01/072-INQ000412487**.

256. On 10 April 2020, I informed Directors of Nursing that the matter had been discussed with NHS Chief Executives, who agreed with the need to expand the workforce, and with the Deputy CMO who indicated he would contact the Critical Care Network to explore their concerns more fully. The minutes of the meeting of 10 April were previously exhibited at **M3CNOW01/85-INQ000412492**.

257. At the meeting on 10 April 2020, further concerns were also raised regarding the setting of ratios for registered nurses to patients in general Covid-19 wards and in field hospitals and a lack of consistency across Wales. At the meeting of the Nurse Directors on 13 November 2020, further concerns were raised regarding staffing ratios in field hospitals and particularly that Directors were finding the agreed ratios to be challenging. It was agreed that ratios would be shared with peers and risk assessments undertaken. A copy of the minutes for the meeting of 13 November 2020 were previously exhibited at **M3CNOW/076- INQ000412576.**

General concerns about capacity

258. At the meeting of the Nurse Directors on 20 November 2020 the Nurse Directors raised concerns about the limited number of nursing staff available due to an increased rate of absenteeism. There were also issues raised regarding the wellbeing and resilience of staff. It was agreed that more work needs to be done by HR departments on the quality of workforce wellbeing and absenteeism data in order to further understand the position on the challenges faced. I exhibit the minutes of the meeting dated 20 November 2020 at **M3CNOW01/102-INQ000412577**. At a follow up meeting on 27 November 2020, it was noted that **Name Redacted**, Nursing Officer at the Welsh Government was working with workforce policy colleagues within Welsh Government in addressing the issue, and on 4 December 2020, **Name Redacted** circulated examples of data submitted by the workforce and noted that those health boards/trusts using electronic and paper-based systems were experiencing the most difficulties. I exhibit minutes of the meeting dated 27 November 2020 at

M3CNOW01/103-INQ000412578 and 4 December 2020 at **M3CNOW01/104-INQ000412579.**

259. At the meeting of the Nurse Directors on 11 December 2020 the Nursing Directors raised concerns that the staffing levels were very stretched. Greg Dix, the Executive Director of Nursing at Cwm Taf Morgannwg University Health Board agreed to share his current plans regarding stretching the resource available to maintain services which included stopping some procedures. I reminded everyone to record decisions that they were taking about staffing levels given that the requirements of the Nurse Staffing Levels Act had not been suspended. I exhibit the minutes for the meeting on 11 December 2020 at **M3CNOW01/105-INQ000412580.**

260. At the meeting on 18 December 2020 the Nursing Directors again raised concerns about the pressures on nursing staff and requested that the planned January audit of medical and surgical wards be stood down. I agreed to cancel the January audit, and I also sought views on ways that we could ease the staffing concerns such as exploring what health professional students could do to support service delivery without disrupting their training. It was noted that pushing through nursing students to register early would help with winter pressures in order to free up experienced workforce, and that the national bank could also be helpful in the short term (e.g. by helping with the mass vaccination programme). I exhibit the minutes for the meeting on 18 December 2020 at **M3CNOW01/106-INQ000412582.**

261. At the meeting of the Nurse Directors on 8 January 2021, concerns were raised regarding ICU nurses being offered more money to work in other health boards on an agency basis which was putting pressures on staffing levels. It was agreed that this would be investigated on a local level. I exhibit the minutes for the meeting on 8 January 2021 at **M3CNOW01/107-INQ000412583.**

Gareth Howells

262. A lack of nurses or midwives was a constant worry, but was not a concern formally raised with me during my period as CNO, though I was aware through discussions with Nurse Directors at our meetings that this was a challenge in the context of the

pandemic. The Directors of Nursing within the Health Boards undertook a great deal of focused work on staffing throughout the pandemic and made use of the systems that had been set up such as the reassessment of staffing levels, use of bank and agency staff, overtime, access to the temporary register, re-deploying therapy staff and student deployment

263. I did not take any new additional steps, beyond those already taken by Jean White, to increase the number of nurses or midwives in Wales during my brief tenure as CNO.

Sue Tranka

264. At the time at which I joined the Welsh Government as CNO, measures had already been initiated by my predecessor to increase the numbers of nurses/midwives in Wales to support the acute phase of the pandemic.

265. During the Omicron resurgence, Nurse Directors did not directly raise concerns with me regarding a need for new initiatives to increase the numbers of staff. They mitigated short term sickness with use of agency and bank workers.

Training and support, including mental health and wellbeing support, for nursing and/or midwifery staff who were returning retirees, students deployed early, redeployed non-clinical staff or volunteers

Jean White

266. I have described above in paragraph 216 my involvement in changes to the education standards that modified the training of pre-registration nursing and midwifery students and created a temporary register for specific groups of staff, including recently retired staff who wished to return to practise.

267. I played no direct role in formulating mental health and wellbeing support for nurses and midwives. I have referred later in this statement, under the heading 'Impact of the Covid-19 pandemic on the mental health and well-being of nursing staff and midwives during the relevant period', to work undertaken by Health Education

Improvement Wales and support from the Samaritans to ensure staff support was available.

Gareth Howells and Sue Tranka

268. During our respective tenures as CNO we had no involvement in training and support, including mental health and wellbeing support, for nursing and/or midwifery staff who were returning retirees, students deployed early, redeployed non-clinical staff or volunteers during the relevant period.

Testing for nursing staff and midwives

Nursing staff, healthcare assistants, and midwives' access to Covid-19 tests

Jean White and Gareth Howells

269. During our respective tenures as CNO we played no role in ensuring nursing and midwifery staff were able to access Covid-19 tests.

Sue Tranka

270. As CNO I have not played any direct role in ensuring nursing and midwifery staff were able to access Covid-19 tests during the relevant period. Testing policy was established and implemented in Wales when my role was taken up. National guidance was already widely available for staff who needed to undertake testing – when to test, what type of test to take (PCR or LFD), what to do in the event of a positive test, when to return to work etc. This was also based on evidence from TAG and its sub-group on testing.

271. The policy of testing health and social care staff was monitored through discussions in TCAP (Testing Clinical Advice and Prioritisation Group) and joint meetings with the nosocomial groups and by reviewing the numbers of tests ordered by settings through the organisational portal. This would have involved nursing colleagues from the CNO office.

The formulation of guidance on self-isolation of nursing staff and midwives following a positive Covid-19 test

Jean White, Gareth Howells and Sue Tranka

272. As CNOs we have played no role in the formulation of guidance on the isolation of nursing staff or midwives following a positive test.

Covid-19 related staff absences

Jean White, Gareth Howells and Sue Tranka

273. Management information on NHS staff absence was requested from all NHS Wales bodies to support transparency and understanding of workforce capacity. Data was collected daily from 20 April 2020 (excluding Swansea Bay UHB which was not able to submit data on the same basis as the other organisations until 25 May, the Welsh Government is unclear of the reason but note this from the Stats Wales statistical quality information) until 9 August 2020, then once a week or fortnightly depending on the Covid-19 situation at the time.

274. In response to the Covid-19 pandemic, StatsWales published information covering the period from 14 April 2020 on NHS staff absence to support transparency and understanding of NHS activity and capacity. Figures show the number and percentage of NHS staff absent due to COVID-19 related illness, self-isolation or otherwise and, from January 2022 onwards, the percentage absent by staff group. I exhibit these in **M3CNOW01/107a – INQ000474030, M3CNOW01/107b – INQ000474027**and **M3CNOW01/107c –INQ000474028,** respectively. The data are taken from management information and was not subject to the same validation processes undertaken for official statistic releases.

Jean White and Gareth Howells

275. We were aware during our tenures as CNO (and, for Gareth Howells, in my previous role as a nurse executive) that staff absences due to Covid-19 were a reality of the pandemic, and one of the major challenges. This led to frequent discussions between

the Local Health Board Executive Nurse Directors during our regular meetings. It is important to note however that these challenges were managed by the Local Health Boards. It was not a matter that was escalated to the CNO or lobbied the CNO for the Welsh Government to intervene.

Jean White

276. By way of example, I recall being informed that Cwm Taf Morgannwg University Health Board had to close its midwife-led unit between March 2020 and October 2020 midwives because of staff illness. Homebirth services were unaffected during this period but this still meant that women's choice of where to give birth was curtailed for a period. This matter was managed by the Health Board and I was informed as the policy lead for maternity services in NHS Wales rather than being requested to make a Welsh Government intervention. Cwm Taf Morgannwg University Health Board maternity services were in special measures at this time so were subject to enhanced scrutiny by the Welsh Government, including reporting of changes to maternity services. Changes to maternity services in other Local Health Boards were not necessarily reported to the Welsh Government because this was an operational matter and no other maternity services had the same level as scrutiny.

Sue Tranka

277. I did not play a role in Local Health Board operational mitigation, deployment of staff or management of clinical services. All local decision making is for the leadership of health boards and trusts to undertake.

278. Four nation CNO discussions took place at intervals when Covid-19 cases were rising in the community or admissions were increasing, in order to discuss impact on nurses, midwives and healthcare support workers, and to understand UKHSA position in relation to any changes to the transmission of the virus.

Redeployment of nursing staff and/or midwives

Jean White

279. I did not generally intervene in the redeployment of nursing or midwifery staff, as this was a matter for Local Health Boards. However, on 7 April 2020 I was asked to intervene on behalf of the Renal Network to contact Directors of Nursing to ensure that specialist renal nurses were maintained to support both COVID and non-COVID patients requiring dialysis and not redeployed. This redeployment was materially affecting the care of patients requiring treatments such as dialysis. As dialysis is a nurse-led service and essential to maintaining the life of patients dependent on the therapy, I emailed Directors of Nursing that day. I am unable to locate a copy of that email but an email exchange on 8 April 2020 confirming that I had contacted Directors of Nursing the previous night is exhibited at **M3CNOW01/108-INQ000412486**. I received feedback that this was acted upon to the betterment of care for patients who could have had acute renal injury if their dialysis was delayed or stopped.

280. I was also asked to intervene in the same way by the Renal Network in December 2020 and a copy of my email to Directors of Nursing on 23 December 2020 requesting that specialist renal nurses should not be redeployed is exhibited in **M3CNOW01/109-INQ000412532**.

Gareth Howells and Sue Tranka

281. As CNOs we played no role in the redeployment of nursing or midwifery staff during the relevant period. These were matters for Local Health Boards.

Concerns regarding training, suitability and support in relation to redeployed nursing and/or midwifery staff

Jean White, Gareth Howells and Sue Tranka

282. We have been asked to provide details of any issues or concerns of which we were aware regarding the lack of relevant training, the suitability of roles or the support for

redeployed nursing staff and/or midwives. In considering this question we have considered the Nurse Directors meeting minutes from our respective tenures.

Jean White

Concerns regarding expertise of critical care nurses

283. At a meeting of the Nurse Directors on 7 April 2020, the Critical Care Network raised a concern over the plans to expand the workforce to assist with surge capacity, and raised specific concerns about the level of expertise of critical care nurses in Wales. Neither the Directors of Nursing nor I recognised any issues with the expertise in the workforce, but I agreed that it would be raised for the attention for Chief Executives of the Health Boards at the next meeting with them that evening. I do not recall any concerns about the clinical expertise of critical care nurses being raised with me by the Chief Executives. I drew the Chief Executives' attention to the impact expansion would have on critical care nursing staff to patient ratios. The minutes of the Nurse Directors meeting on 7 April 2020 were previously exhibited at **M3CNOW01/072-INQ000412487.**

Concerns regarding training needs for returning registrants.

284. It was recognised during the meeting of the Nurse Directors on 7 April 2020 that nurses and midwives who were returning to the profession on the temporary register would need extra support and training and it was agreed that Health Education and Improvement Wales would help Local Health Boards and NHS Trusts with any required training and support where necessary. I raised this again during the Nurse Directors on 21 April 2020. I exhibit the minutes of the meeting of 21 April 2020 at **M3CNOW01/110-INQ000412499**. I do not recall being told the nature of any support put in place by the Local Health Boards, Trusts or Health Education and Improvement Wales.

Concerns regarding training on the verification of death

285. At the meeting of the Nurse Directors on 21 April 2020, it was noted that guidance had been issued which allowed healthcare professionals to verify deaths as long as they had completed the e-training module. I exhibit this guidance, 'Coronavirus (COVID-19): Verifying death in times of emergency' in **M3CNOW01/110a – INQ000081115**. Concerns were raised about the risk of untrained staff being used to verify deaths, and particularly in care homes where a GP was not in attendance. It was agreed that further work was needed to understand the uptake of e-learning on verifying deaths across the NHS to help provide assurances around the new processes. One of the Nursing Officers **Name Redacted** suggested that "Attend Anywhere" software could be used by a qualified medical practitioner to support staff in verifying deaths. I am not aware of whether this suggestion was implemented in practice, which would have been an operational decision for Local Health Boards. The minutes for the meeting dated 21 April 2020 were previously exhibited at **M3CNOW01/110-INQ000412499**.

Gareth Howells and Sue Tranka

286. We are not aware nor were we made aware of any concerns related to a lack of relevant training for redeployed nursing and midwifery staff during our respective tenures as CNO during the relevant period.

Impact and Inequalities

Impact of the Covid-19 pandemic on the mental health and well-being of nursing staff and midwives during the relevant period

Jean White

287. Early on in the pandemic it was recognised that the psychological wellbeing of staff was an issue. The Office of the CNO attended workforce meetings, the subgroup for community and primary care and the acute care subgroup to ensure that all groups were sighted on the issues and to consider the ways in which wellbeing could be managed and supported. I exhibit as **M3CNOW01/111-INQ000412461** an email from

Name Redacted in relation to issues relating to people with mental illness and learning disabilities, and issues for the wider population / staff regarding psychological wellbeing, connected to Covid-19. One of my Nursing Officers, Name Redacted was a member of the workforce deployment and wellbeing cell. She attended meetings with Public Health Wales to discuss the current health and wellbeing of nurses and midwives and how to build resilience and promote wellbeing. I exhibit an example agenda for one of those meetings as **M3CNOW01/112-INQ000412517**.

288. In March 2020, I was made aware of concerns raised in an email from a member of staff at Cwm Taf Morgannwg University Health Board regarding a shortage of PPE on the wards and that staff had threatened to walk out. Concerns included that staff had been told to share masks and were bringing their own PPE from home. The email, the relevant section of which is exhibited in **M3CNOW01/112a – INQ000473918** included a warning that more staff would become infected. I ensured that this was tabled at the PPE Cell meetings which were chaired by Chris Jones, the Deputy Chief Medical Officer (W).

289. In April 2020, due to the higher levels of stress and anxiety caused by Covid-19 the Health for Health Professionals Wales Service (HHP) was provided to all the NHS workforce. This intervention recognised in particular the substantial number of GPs presenting with stress and anxiety as they dealt with a wave of patients and aimed to scale psychological support and extend outreach across the NHS workforce. I exhibit as **M3CNOW01/113-INQ000412490** an email, dated 9 April 2020, to the Minister for Health & Social Services, providing a Ministerial Heads Up Briefing in relation to the enhancement of the Health for Health Professionals Wales Service in response to Covid-19

290. In November 2020 I was contacted by Vaughan Gething, the then Minister for Health and Social Services, following a recent RCN survey which claimed that 34% of staff, nurses in particular, felt undervalued by the Welsh Government and 74% of staff believed they had seen an increase in stress levels. I exhibit as **M3CNOW01/114-INQ000412529** an email, dated 26 November 2020, showing this contact and query

from the Minister. Trade Union/professional association members' surveys provide useful snapshots of what some staff are experiencing. I normally discussed this type of report (pre-pandemic as well as during the pandemic) with the Minister as it is important to understand what the front-line care staff were reporting. Considerable efforts were being made by Health Education and Improvement Wales to ensure staff support was available to alleviate stress, including gaining support from the Samaritans. I formed the view, following discussion with policy leads in the Workforce and Organisational Development Directorate and my Nursing Officer, **Name Redacted** that sufficient action was already being taken and no additional action followed from the receipt of this one report. The resources developed through the pandemic remain available on the HEIW website under the section 'Colleague health and wellbeing'.

291. In January 2021 I was contacted by Dr Julie Highfield, ICU Clinical Psychologist and member of the Intensive Care Society (ICS). This was at a time when I was concerned about the effect of the dilution of bedside nurse to patient ratios due to the surge in Covid 19 cases seen during December and early January leading to greater demands on services and increased staff sickness. Information about the progress of the pandemic and the impact on health and social services was shared at the regular EDT and the Planning and Response Cell briefings that I attended. I was keen to ensure that we put in place support and kept the issue on the agenda of our weekly Nurse Directors meetings. Dr Highfield was promoting a national wellbeing offer for all ICU staff, called the WARE project (Wellbeing and Resilience through Education). I had recently been discussing the issue of mental trauma and long-term effects on critical care staff both internally and with the CNO's in the UK and Ireland. I was keen to work with Dr Highfield and meet with her. I exhibit **M3CNOW01/115-INQ000412540 which** is an email, dated 29 January 2021, showing me contacting Dr Julie Highfield. I also exhibit, as **M3CNOW01/116-INQ000412542**, an Intensive Care Society document in relation to Wellbeing and Resilience through Education.

292. I ensured that I circulated ICS news and wellbeing research so that any discussions with staff about mental health and wellbeing were informed. As an illustration I exhibit

an email chain as **M3CNOW01/117-INQ000412539**. I also arranged for Angela Parry from HEIW to lead a discussion on mental health/wellbeing support for critical care staff to see what else we could be doing to support them.

293. During the pandemic the Welsh Government had the assistance of the Military. I worked with the Military Assessment Team to test our resilience in relation to mental health and wellbeing. The outcome was that there were very good resources already in place to support NHS staff and mitigate against future mental health and wellbeing concerns. I provide an email chain which details the assistance the military provided as **M3CNOW01/118- INQ000412549.**

294. The mental health and wellbeing of nursing staff and midwives was also a recurring theme in the meetings of the Nurse Directors. For example, at the meeting on 15 May 2020 it was noted that, for particular groups of people, their mental health had been adversely affected by Covid-19 including frontline health workers. It was agreed that signposting to third sector support and promotion of the 111 Wales website would be helpful. I exhibit the minutes from the meeting of 15 May 2020 at **M3CNOW01/119-INQ000412513**. In subsequent meetings of the Nurse Directors on 19 May 2020, 31 July 2020, 30 October 2020 and 20 November 2020, concerns were raised about exhaustion and stress within the nursing profession and that improvement was needed in terms of mental health and wellbeing in the workplace. Suggestions for improvement included increased awareness of the HEIW Compassionate Leadership Course and enforced work breaks. I exhibit minutes of the meeting of 19 May 2020 at **M3CMOW01/120-INQ000412515**, 31 July 2020 at **M3CMOW01/121-INQ000412571**, 30 October 2020 at **M3CMOW01/122-INQ000412573** and 20 November 2020 as previously exhibited at **M3CMOW01/102-INQ000412577**. In the meeting of the Nurse Directors on 22 January 2021, further concerns were raised regarding the focus on improving the longer term health and wellbeing of staff following the pandemic and that it was noted that HEIW were undertaking work on that in terms of raising awareness and providing support, as noted above. I exhibit the minutes for the meeting of 22 January 2021 at **M3CMOW01/124-INQ000412584.**

Gareth Howells

295. Having been a nurse executive in a major health provider during the first two waves of COVID-19, I was all too aware of the impact the pandemic was having in all our staff – it was an exceptionally difficult and challenging time, and still see the impact manifesting itself now. I exhibit the minutes of the meeting of the Nurse Directors dated 16 April 2021 at **M3CMOW01/125-INQ000412589** in which there was a general discussion regarding the current challenges experienced by the workforce, including stress.

Sue Tranka

296. Since taking up post in August 2021, I have repeatedly sought assurance that Wales has adequate mechanisms and support offers in place for nurses and midwives experiencing mental health problems and trauma post pandemic. I have reviewed the data for the number of nurses and midwives seeking support in order to understand the demand and scale of the problem. I have been assured that HEIW have invested in Canopi and the Mental Health Helpline for Wales services, which are telephone support lines with trained professionals offering emotional support and information/literature on Mental Health and related matters to the people of Wales. HEIW also have an offer through Able Futures which helps mental health at work by providing advice, information and support and is continuing to deliver mental health support during the COVID-19 outbreak. In addition, Wales offers the provision from Samaritans and signpost all of these nationally. I have equally sought assurance that every Local Health Board and Trust in Wales has a wellbeing and psychological support offer for their staff. To my knowledge, neither the Nurse Directors nor Workforce Directors have raised concerns about the adequacy or effectiveness of the current offer for staff.

Impact of the Covid -19 pandemic on workers including by reference to factors such as sex, age, ethnic or socio-economic background or disability

Jean White

297. The First Minister's advisory group on Covid-19 inequities in Black, Asian and Minority Ethnic communities was set up to specifically address the disproportionate impact of Covid-19 based on genetic and biological diversity. I shared details of this group at the Nurse Directors weekly call on 1 May 2020. In addition I was aware that the NHS in England and Ireland had written to Trusts requesting them to consider where they deployed staff who were known to be at higher risk from Covid-19. I requested that my Directors of Nursing take this into consideration. I exhibit the notes of this meeting as exhibit **M3CNOW01/89-INQ000412509**.

298. I was aware of the socioeconomic report published by the Covid-19 Black, Asian and Minority Ethnic Advisory group on 22 June 2020. In particular, I was asked, alongside Frank Atherton, to look at how we could reduce structural inequalities in the NHS in Wales. One of the recommendations in the report was that the CNO and CMO should establish and monitor a reporting mechanism for workplace equity using a workforce race equality standard tool, and use this data to develop a strategy to address inequalities, with regular review and reporting to the NHS Board. I exhibit as **M3CNOW01/126-INQ000412523** an email (dated 22 June 2020) from Heather Payne to myself and the CMO, which attaches the Achieving Race Equality in NHS Wales paper, and the paper itself as **M3CNOW01/127-INQ000412524**. The work to develop and implement a workforce race equality standards tool (WRES) was taken forward through the development of the Welsh Government's Anti-Racism Wales Action Plan that was published in June 2022 and which I exhibit in **M3CNOW01/127a – INQ000227788**. This postdated my tenure as CNO, though I note that I was part of the team that developed the consultation document called "the Race Equality Action Plan – an anti-racist Wales" consulted on in 2021, designed to address historic poor workforce data on racial disparities. The WRES will be used to measure the impact

of wider actions in the Anti-racist Wales Action Plan to ensure Wales is an anti-racist nation by 2030.

299. Factors including sex, age, ethnicity, and medical disposition and their impact on the risk profile for Covid-19 were also raised on a number of occasions during the meetings of the Nurse Directors. For example, at the Nurse Directors meeting on 10 April 2020, a concern was raised by Ruth Walker, Nursing Director at Cardiff and Vale University Health Board about the deployment of returning staff aged over 60, particularly given the number of older health workers who appeared to have been affected in Italy. At the 24 April 2020 meeting, Ruth Walker updated that Cardiff and Value had opted not to deploy over 60s into Covid area and was reviewing staffing arrangements, noting that some staff were anxious about moving into different areas. She indicated she would share details with the other Directors of Nursing. The minutes of the meeting dated 10 April 2020 were previously exhibited at **M3CNOW01/085-INQ000412492**.

300. I felt that it was very important that the Nurse Directors were aware of any evidence on the relationship between certain factors and an increased risk of infection by Covid-19. At a meeting of the Nurse Directors on 21 April 2020, I advised that a written statement outlining that people from Black, Asian and Minority Ethnic backgrounds were more at risk from infection by Covid-19. The minutes from the meeting of 21 April 2020 were previously exhibited at **M3CNOW01/110-INQ000412499**. At the meeting of the Nurse Directors on 24 April 2020, I circulated further evidence including an article about the death of healthcare workers being disproportionately from Black, Asian and Minority Ethnic communities. I previously exhibited the minutes from the meeting of 24 April 2020 at **M3CNOW01/74-INQ000412508**. In the meeting of the Nurse Directors on 28 April 2020, it was further highlighted that evidence shows that people from ethnic minority backgrounds (and in particular the Indian sub-continent) are more at risk of severe illness/death from Covid-19 but that further research was needed to understand why. Other factors such as exposure to the virus, obesity, diabetes and older age also appeared to be relevant factors in determining worse outcomes. Evidence also suggested that men

had worse outcomes than women. I agreed to share further evidence as it became available, and I also asked the Directors of Nursing to consider individual staff cases when looking at whether to deploy staff to Covid-19 areas rather than to make decisions for groups of people, to understand the individuals' risk profiles as according to these factors. The minutes from the meeting of 28 April 2020 were previously exhibited at **M3CNOW01/88-INQ000299245.** At the meeting of the Nurse Directors on 1 May 2020, I reiterated to the Directors of Nursing the need to take into account the various risk factors in deploying members of staff to Covid-19 areas. I also advised that Public Health England would be publishing guidance on it shortly. The minutes from the meeting of 1 May 2020 were previously exhibited at **M3CNOW01/89-INQ000412509**. At the meeting of the Nurse Directors on 12 May 2020, it was noted that pregnant women in their third trimester were most at risk of complications from Covid-19 and I shared the relevant study on that. The minutes of the meeting on 12 May 2020 were previously exhibited at **M3CNOW01/100-INQ000299276.**

Gareth Howells

301. Having been a nurse executive in a major health provider during the first two waves of COVID-19, I was all too aware of the impact the pandemic was having in all our staff. It was an exceptionally difficult and challenging time, and we still see the impact manifesting itself now.

Sue Tranka

302. I have had no involvement in the advisory group on Black, Asian and Minority Ethnic communities report, other than to support the design workshops for implementation of one of the key recommendations: the Workforce Race Equality Standard ('WRES'). When I was appointed as the CNO, the Workforce & Organisational Development ('WOD') Director was leading a group to design and deliver the WRES. I was a member of that steering group and provided input from my previous role in England on the benefits and drawbacks of an effective WRES. A scoping exercise was conducted in April 2022 to agree the workforce reporting

requirements to measure progress in race equality across Primary, Secondary and Social Care and identify data to catalyse systemic, organisational level change. For the first time in April 2024, NHS Health Boards, Trusts and Special Health Authorities will have collected data on the disparity of the experience of their Black, Asian and Minority ethnic workforce. A national Workforce Race Equality Standard (WRES) report will be published in June 2024, and produced annually thereafter. The report will describe the racial disparity in staff experience of bullying, harassment, leadership, progression, training, and recruitment and pay and provide an evidence on which organisations can develop target actions within local anti-racist action plans. The WRES for Health and Social Care will provide workforce data disaggregated and analysed by gender and ethnicity, providing an evidence base on which to make targeted interventions to address intersectional inequality. The implementation of the WRES across Health and Social care will be iterative. The first data collection for Health Boards, Trusts and Special Health Authorities concluded on 19 April 2024, with data collection for Primary Care and Social care taking place in the autumn of 2024.

303. Since taking up the role of CNO, staff have contacted me to raise their concerns around the impact of Long Covid. I have described my work in relation to Long Covid later in this statement.

Infection Prevention and Control ("IPC") guidance

Jean White

304. The development of the UK IPC guidance was undertaken by clinical experts in Public Health Wales, including Gail Lusardi, Nursing Consultant in IPC and Dr Eleri Davies, Director of Welsh Healthcare Acquired Infection programme. They updated the Welsh Government through the Nosocomial Transmission Group that I co-chaired with the Deputy CMO. All suggested changes to the IPC guidance were discussed by the group members and fed back into the UK working group. I do not recall providing any additional comment outside of these group discussions.

Gareth Howells

305. I had no involvement in the formulation of Covid-19 IPC guidance for healthcare settings during my tenure as interim CNO.

Sue Tranka

306. In December 2021 I, along with the other Chief Nursing Officers raised concerns about the UK IP&C Cell guidance in light of the Omicron variant. We commissioned the UK IP&C Cell to undertake a review of the evidence and guidance to provide a view on whether the guidance needed to be enhanced given the emerging variants, respiratory and winter virus and increased staff absences. A copy of my email to Dr Eleri Davies, Chair of the UK IP&C Cell, and her response was previously exhibited in **M3CNOW01/068- INQ000227346**.

Guidance on the type and standard of PPE and RPE that nursing staff and midwives should use in the workplace

Jean White, Gareth Howells and Sue Tranka

307. The CNO played no role in providing advice or guidance as to the types of personal protective equipment (PPE) and respiratory protective equipment (RPE) that nursing and midwifery staff should use in the workplace.

Involvement in testing or assessing the adequacy, standard or fit of PPE and RPE for nursing and midwifery staff

Jean White

308. One of the early challenges the Welsh Government faced was in securing sufficient quantities of PPE for use in the health and social care services. We did not produce equipment in-country and therefore had to rely on supplies from other countries, and these supply chains became unreliable. Alan Brace, Director of Finance in the Department of Health and Social Services, attended the PPE Cell to address all issues related to the supply of PPE in Wales, headed by Lee Waters MS. In the EDT meeting on 8 April 2020, Alan reported on the difficulties being experienced, e.g., the

presence of counterfeit equipment that didn't offer protection to the wearer. It was the consensus view that Wales should work with the UK Government to utilise their sourcing resources, ensuring Wales was then allocated its share of the equipment secured in this way, rather than try to go alone. The longer the pandemic went on, and with increasing demand, there was a real possibility that Wales could run out of equipment. After the EDT meeting on 8 April 2020, Dr Andrew Goodall spoke to Simon Stevens, CEO NHS England, to ensure good working arrangements in this area. Working arrangements did improve over time, so much so that on occasion mutual aid between the four UK countries enabled some sharing of PPE when difficulties were identified. Wales both received from, and provided equipment to, other nations in the UK during the pandemic. I produce here, as exhibit **M3CNOW01/128– INQ000353497**, the notes of the EDT meeting on 8 April 2020.

309. Issues regarding the fit and suitability of PPE were also raised with me during the meetings of the Nurse Directors. For example, in the meeting of the Nurse Directors on 3 April 2020 concerns were raised around FFP3 facemasks that are used in critical care in terms of them not being fully waterproof and that staff were resorting to double masking. Minutes of the meeting of 3 April 2020 were previously exhibited at **M3CNOW01/71- INQ000412477**. General concerns regarding the quality of PPE were also raised in the meeting of the Nurse Directors on 14 April 2020 and further specific issues around the FFP3 face masks regarding their fit and straps perishing in the meeting of 15 May 2020. I agreed to circulate the NMC statement on PPE and pass on issues to the PPE Cell. I exhibit the minutes of the meeting dated 14 April 2020 at **M3CNOW01/129-INQ000299164** and 15 May 2020 as previously exhibited at **M3CNOW01/119-INQ000412513**. At the meeting of the Nurse Directors on 19 May 2020, I informed the Directors that all masks had been cleared by the Health and Safety Executive for use, following age accelerated testing. One of the Nurse Directors noted that up to 50% of FFP3 masks were failing fit testing. The minutes of the meeting of 19 May 2020 were previously exhibited at **M3CNOW01/120-INQ000412515**. I raised this issue with David Goulding, Health Emergency Planning Adviser and member of the PPE Cell, who had previously advised on the Health and Safety Executive's clearance, to again express the concerns made by the Nurse

Directors with regards quality of these stored FFP3 masks. David informed me that the procurement lead in NHS Wales Shared Services, Mark Roscoe, was addressing this matter as part of his work to secure sufficient PPE supplies for Wales. I took no further action after this as the matter was being addressed by the procurement team and PPE Cell.

310. At a meeting of the Nurse Directors on 24 April 2020, the minutes of which were previously exhibited at **M3CNOW01/74 – INQ000412508**, it was also raised that there had been an ITV news story that out-of-date PPE was being used. The meeting minutes note that I confirmed to the Directors that the PPE had been assessed and confirmed as being safe to use. While I cannot recall for certain the basis on which I confirmed this, the procurement team within NHS Shared Services alongside the Welsh Government policy leads in the PPE Cell who dealt with NHS equipment and supplies had responsibility for ensuring any supplies that had been previously stockpiled were fit for use. They would normally work with the Health and Safety Executive if there were concerns about the safety of any item destined for clinical use and I would seek advice from them if asked about the safety of equipment or other supplies, which I believe is what would have occurred in this instance. I understand, in preparing this statement, that the Welsh Government was informed on 21 March 2020 by Public Health England that the Health and Safety Executive had given its clearance for 3M FFP3s to be used by the NHS. That clearance followed batches of the 3M FFP3s, which included some from Wales, undergoing quality assurance age accelerated testing. As far as I am aware that clearance for use was not changed during my tenure as CNO.

Gareth Howells

311. I played no role in testing or assessing the adequacy, standard or fit of PPE and RPE for nursing and midwifery staff during my role as CNO.

Sue Tranka

312. Given the stage of the pandemic at which I joined the Welsh Government, procurement issues of PPE/RPE and fit testing concerns had already been addressed with more sustainable solutions in place.

Awareness of any PPE or RPE shortages for nursing staff and midwives

Jean White

313. At the meeting of the Nurse Directors on 14 April 2020, it was brought to my attention that the PPE supply chain was fragile and that the four nations were in discussion about contingency plans. Mutual aid across the UK was agreed to make the best use of the PPE that we already had, and that the Nursing and Midwifery Council would be issuing guidance shortly. I agreed to circulate the Nursing and Midwifery Council guidance to all Directors of Nursing once it became available. I previously exhibited a copy of the meeting minutes on 14 April 2020 at **M3CNOW01/129- INQ000299164**.

314. At the meeting of the Nurse Directors on 17 April 2020, I was made aware that parts of England were experiencing extreme shortages of items such as waterproof gowns but that Wales was unable to help with gown shortages as our supplies were also limited. It was noted during that meeting that PHW, together with the CMO, had been involved in developing contingency guidance should any PPE items run out, including use of alternative items. I agreed to share the contingency arrangements once they had been issued. A copy of the meeting minutes on 17 April 2020 were previously exhibited at **M3CNOW01/086-INQ000412495.**

Gareth Howells and Sue Tranka

315. We are not aware of any concerns raised in relation to PPE shortage during our respective tenures as CNO, during which there were good supplies of PPE in place.

Nosocomial transmission and the work of the Nosocomial Transmission Group

Jean White

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

317. The purpose of the NTG was to provide advice, guidance and leadership on the actions needed to minimise the nosocomial (infection(s) acquired during the process of receiving health care that was not present at the time of admission) transmission of Covid-19, and to enable the safe resumption of routine services in health and social care settings. The work covered hospitals, primary and community care settings, prisons, registered care homes, domiciliary care, and learning disability units. The group developed and oversaw the implementation of infection prevention and control measures ("IPC"), including patient and staff isolation and testing. I produce here the terms of reference of the NTG, as exhibit **M3CNOW01/135–INQ000252576**.

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

    a. evidence based guidance

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

    c. leadership in IPC

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

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

319. Membership was made up of the following:

    a. Welsh Government officers (18 people): CNO(W), DCMO(W), nursing officers, senior medical officers, social services, the Chief Dental Officer,

and policy leads for infection prevention, communicable disease control, quality and safety, population health, housing, and environmental health

b. Public Health Wales (3 people)

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

d. Health Education and Improvement Wales

e. NHS Shared Services

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

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

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

a. Guidance on the care of a deceased person who was positive for the Covid-19 virus, issued on 14 May 2020 (which I produce here as exhibit **M3CNOW01/136–INQ000299100**). This guidance was endorsed by NTG but produced originally by Public Health England. The guidance sets out safe practice for handling the body of a person who was positive for the Covid-19 infection, as they remained a health risk to others. This included instructions for clinical staff who had been caring for the person (inside and outside hospital), through transport and housing in the mortuary, those supporting or involved in faith or belief practices, and transfer to funeral directors. The NTG wished to ensure the body was handled with respect, while at the same time ensuring the virus was not passed on to staff during the end stage of care.

b. Operational guide for the safe return of healthcare environments to routine arrangements following the initial Covid-19 response, issued on 3 June 2020 (which I produce here as exhibit **M3CNOW01/137–INQ000299367**). This guidance provided practical guidance on areas such as signage, communication with staff and visitors, social distancing, infection control measures, adapting reception desks and waiting room areas, managing staff break out and canteen areas, managing administrative staff areas, and reminding organisations that any changes must be done with the agreement of the fire officer.

c. Covid-19 guidance on bed spacing in healthcare, issued on 26 June 2020 (which I produce here as exhibit **M3CNOW01/138– INQ000299554**). I also wrote a follow up letter dated 17 August 2020 to clarify how the spacing was to be calculated, i.e., 3.6 metres from the centre of one bed to the centre of the next bed as this ensures a minimum 2 metre distance between the sides of the bed. I produce here that letter, as exhibit **M3CNOW01/139–INQ000299553**). Developing a workable approach was discussed by NTG members. Issues included the impact of the bed space policy on how many beds could be physically contained in ward bays, which could in some circumstances result in an overall reduction in bed capacity if beds had to be removed from a bay area. Consideration was given to whether bed screens of different types could be used to mitigate the need to take beds out of areas, and whether the use of fans and other ventilation had a material impact on the airborne spread. Considering evidence from published sources was part of the decision-making process. Infection prevention experts within the group helped determine the policy position on this. Concern about the impact of the policy on bed capacity was discussed with chiefs of operations via the Essential Services Cell, and NHS Wales chief executives. Consideration was also given to how these rules applied to the social care settings, as part of the decision-making process.

d. Operational guide for the safe return of general medical practice premises to routine arrangements following the initial Covid-19 response, issued on 1 July 2020 (which I produce here as exhibit **M3CNOW01/140–INQ000299430**). This set out the principles to be used when reconfiguring premises to enable patients and staff to return safely and give people confidence when accessing services. It emphasised the importance of social distancing, face mask wearing, hand hygiene, and good signage.

e. Restricting the movement of bank, agency and locum staff was identified as important in stopping the transmission of Covid-19 within health settings. Guidance was issued on 10 July 2020, which I produce here as exhibit **M3CNOW01/142–INQ000300111**. This guidance reminded managers about the need to cohort patients who were known to be positive or were suspected as being positive to the virus. It also reminded managers about the national infection prevention and control guidance, use of personal protective equipment (PPE), and the guidance on dealing with staff inadvertently exposed to the virus.

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

letter to health and social care providers which accompanied the revised UK IPC guidance, to explain how that guidance should be applied in social care settings. I produce here: the UK infection prevention and control revised guidance 2020, as exhibit **M3CNOW01/143–INQ000299582**; the minutes of the NTG meeting on 27 August 2020 where this guidance was discussed, as exhibit **M3CNOW01/144–INQ000300112**; the Welsh Government's guidance on the use of face masks in non-clinical settings then in force, as exhibit **M3CNOW01/145–INQ000299379**; and the cover letter that I wrote with the CMO(W) to explain the approach in Wales and application of the UK guidance in Welsh care settings, as exhibit **M3CNOW01/146–INQ000299567**.

g. Ahead of the annual autumn influenza vaccination programme and the planned Covid-19 round of vaccinations that coincided with this, a letter and guidance, referred to as an SBAR (Situation, Background, Assessment and Recommendation) report was issued to NHS Wales services from me and CMO(W). This guidance had been prepared by Gail Lusardi, Consultant Nurse in Infection Prevention and Control at Public Health Wales. The guidance included reference to PPE, infection prevention and control measures, safe disposal of waste, signage and communication with the public while in vaccination venues. I produce here, as exhibits **M3CNOW01/147–INQ000300010** and **M3CNOW01/148–INQ000300222**, the guidance on infection prevention and control in vaccination centres and the cover letter issued by myself and the CMO(W) respectively.

h. Interim operational guidance for the safe recovery of routine community group interventions (this was mainly mental health related services) following the initial Covid-19 response, issued in October 2020 (which I produce here as exhibit **M3CNOW01/149– INQ000081502**).

i. A framework for testing patients for Covid-19 in hospitals, including community hospitals, hospices, mental health and learning disability

inpatient settings, issued on 22 January 2021, in support of the revised strategy for testing people in Wales. I produce here the framework as exhibit **M3CNOW01/150–INQ000299767**. The purpose of this framework was to prevent the virus entering, or being transmitted within, the health and care system. It covered various situations: those being admitted for elective surgical care; protecting those following an emergency care pathway to prevent nosocomial transmission as far as possible; identifying patients who had recovered from Covid-19 and who were able to proceed with planned interventions; providing protection for patients in high-risk groups who may have other underlying medical conditions that made them vulnerable, e.g., patients undergoing renal dialysis or patients with cancer; and confirming non-infectivity prior to discharge e.g., to care homes.

321. A dedicated working group was established, under the leadership of Mandy Rayani, Executive Nurse Director of Hywel Dda University Health Board and Chair of the NHS working group on health care acquired infections ("HCAI"). This HCAI working group pre-dated the pandemic and reported directly to the Nurse Directors. However, it seemed sensible to build on existing structures and relationships, so the NTG working group on healthcare acquired Covid-19 drew upon the HCAI's existing structures and expertise. This working group revised the NHS cleaning standards in light of the Covid-19 outbreak. I produce here, as exhibit **M3CNOW01/151–INQ000299708**, the revised NHS cleaning standards produced by the working group, and as exhibit **M3CNOW01/152–INQ000300113**), the minutes of the NTG meeting where these standards were discussed. The revised cleaning standards and advice on ventilation in healthcare settings was issued by the Director-General in December 2020 to the NHS Chief Executives. This route was chosen due to the financial consequences identified with the new standards.

322. It was important that any lessons learned from NHS Wales were shared quickly to ensure good practice was promulgated across the system. To this end, the NHS Wales Delivery Unit established the Covid-19 Rapid Sharing of Early Learning platform at the behest of the NTG. A letter was sent to the Nurse Directors and

executive medical directors advising them about this new platform on 6 August 2020, and I produce here this letter as exhibit **M3CNOW01/154–INQ000300114**, and a copy of the platform as exhibit **M3CNOW01/156–INQ000299502**. This platform did not require any changes to the reporting or investigation of in-hospital transmission of Covid-19 infections under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ("RIDDOR"), or the Welsh Government's no surprises and serious incidents reporting arrangements.

323. It became evident over time that the no surprises and serious incidents reporting arrangements, established pre-pandemic, were burdensome, due to the volume of Covid-19 cases that needed to be reported. On 9 November 2020, instructions were sent to NHS Wales executives to streamline the system to ensure that cases were captured, and outbreaks were managed appropriately. A new form was issued that asked for a daily return of cases, their location, communication plans and outbreak management plan. This was sent to Public Health Wales and the Welsh Government Health Protection mailbox and copied to the co-chairs of the NTG. I produce here copies of the instructions, as exhibit **M3CNOW01/157–INQ000300116**, and the reporting form, as exhibit **M3CNOW01/158–INQ000300117**. In this way it became much easier for the NTG to monitor hospital outbreaks of the disease across the whole of NHS Wales because the information gave greater detail of where outbreaks were occurring, if they were being contained or not, and whether the interventions were working. This approach enabled us to identify good practice on outbreak management that was then shared with those who were finding it difficult to contain spread of the virus within clinical settings. The information gathered was shared with officials in the Welsh Government to support their response work and combined all-Wales weekly outbreak reports prepared. These reports summarised the all-Wales and each individual health board position noting if the situation was stable, improving or deteriorating and noting examples of what measures were in place to respond to the situation. An example of this weekly report is exhibited in **M3CNOW01/158a – INQ000473936.** The reports were shared via the Planning and Response Group meetings and provided an opportunity for signposting senior managers in Local Health Boards where outbreaks were not being well controlled to get in contact with

those Local Health Boards who seemed to have gained a quicker control on the spread of disease. These peer interactions were not reported back centrally. Examples of good outbreak management practice I recall being shared included: approaches to cohort infected patients and modified care pathways to limit patient movement within the hospital; increased point-of-care Covid -19 testing that gave a more accurate epidemiological picture and enabled daily clinical decisions to be made on where patients were to be cared for; limiting the movement of staff so they did not move between areas where patients were being cohorted due to Covid-19 infection and areas where there were no confirmed Covid 19 cases; and local reinforcement of infection prevention.

324. The NTG discussed potential routes of transmission at most meetings. One area the members of the NTG focussed on was the impact patients admitted to hospital had on the transmission of the Covid-19 infection within the hospital. Unfortunately, many patients admitted to hospital were symptom-free or were in the pre-symptomatic phase of the illness and therefore not exhibiting the signs of infection. The policy requiring testing of all hospital patients was issued on 15 July 2020 (which was previously exhibited as exhibit **M3CNOW01/066–INQ000300110**, at paragraph 196 of this statement). This guidance built on the stipulation for testing all patients admitted to hospital previously set out in the guidance "A principles framework to assist the NHS in Wales to return urgent and planned services in hospital settings", issued on 3 June 2020 (which I produce here as exhibit **M3CNOW01/161–INQ000299363**). The DCMO(W) and I felt it necessary to issue a letter to NHS Wales directors on 22 September 2020, reminding them to follow this guidance in respect of all admissions, planned, urgent or emergency (which I produce here as exhibit **M3CNOW01/162–INQ000299999**), as we remained concerned about the introduction of infection from the community and the negative consequences this would have on our ability to deliver essential health services.

325. The NTG asked for a report from the independent sector who provided care to patients with mental health and learning disability needs as these were particularly vulnerable groups of people (20 units). A report was presented on 25 November by Alan Pryse, Healthcare Inspectorate Wales, which showed how the two waves of infection so far had affected residents. Particularly of note was concern about the lack of contact that patient aged 13-18 had been having with their families. It was agreed that work needed to be undertaken to improve support in these units and independent providers were tasked with establishing or improving facilities to enable remote/virtual calls with families. This work was led by the National Collaborative Commissioning Unit. I produce the minutes of the NTG meeting on 25 November 2020, as exhibit **M3CNOW01/163–INQ000299595.**

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

Gareth Howells

327. On 4 June 2021, I chaired a meeting of the Nosocomial Transmission Group, where it was reported that while "concerns remain around the Delta variant, transmissibility and vaccine efficacy", "Generally, the position is positive. The seven-day case rate is down to 8/100,000, most areas are below 15/100,000 cases. Conwy has the highest case rates, associated with a local outbreak. Hospital and critical care admissions at this time are significantly lower compared with the peak." I produce here the minutes of that meeting, as Exhibit **M3CNOW01/164 – INQ000271887**.

328. The Nosocomial Transmission Group was exceptionally important at this time and throughout the pandemic, for the purpose of providing advice, guidance and leadership for all health and care settings in Wales including hospitals, primary and

community care, registered care homes, domiciliary care, learning disability units, and prisons.

329. On 2 July 2021, Chris Jones, the Deputy Chief Medical Officer and I wrote to chief executives, medical directors, and nursing directors in NHS bodies in Wales to remind them of their responsibilities to take action to protect hospitals and patients, considering the risk posed by increasing community transmission linked to the Delta variant. Specifically, we reminded NHS trusts and local health boards of the need to implement risk assessments and the hierarchy of control measures set down in the UK infection prevention and control guidance, environmental modifications and signage to ensure adequate ventilation and social distancing, staff and patient testing, and vaccination for healthcare workers. I produce here a copy of this letter, as **exhibit M3CNOW01/165 – INQ000271915**, and a copy of the UK infection prevention and control guidance, as **exhibit M3CNOW01/166 – INQ000271659**.

Sue Tranka

330. The Nosocomial Transmission Group was established prior to my arrival at the Welsh Government. I held the role of co-Chair of the Nosocomial Transmission Group with the Deputy Chief Medical Officer.

331. I produce here, exhibit **M3CNOW01/135– INQ000252576** the terms of reference for the Nosocomial Transmission Group when I joined the Welsh Government. The Group reviews the terms of reference from time to time and the amended terms of reference for the Group dated 6 January 2022 as exhibited in **M3CNOW01/167– INQ000353418**.

332. The purpose of the Nosocomial Transmission Group was to provide advice, guidance and leadership for all healthcare and care settings in Wales on the actions needed to minimise nosocomial infection and enable the safe resumption of services. This included hospitals, primary and community care settings, registered care homes, domiciliary care, learning disability units, and prisons.

333. The Group's work covered: -

a. evidence based guidance.

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

c. leadership for infection prevention and control.

d. awareness, education, and training in infection prevention and control; and

e. creating a culture of infection prevention and control as everyone's business.

334. Membership of the Nosocomial Transmission Group included: -

a. Chief Nursing Officer (Co-Chair)

b. Deputy Chief Medical Officer (Co-Chair)

c. Welsh Government policy leads

d. Public Health Wales

e. HCAI Delivery Board Chair

f. Nurse Director representative

g. Health Education and Improvement Wales ("HEIW")

h. Shared Services Partnership

i. Academy of Medical Royal Colleges Wales

j. A representative from the Partnership Board

335. Information, system updates and guidance produced by the Nosocomial Transmission Group was shared with Local Health Boards. The Nosocomial Transmission Group also provided updates on specific areas of infection prevention, such as testing and the use of face masks in clinical settings.

336. Shortly after I joined Welsh Government, an internal assurance audit was undertaken in September 2021 to understand and evaluate the effectiveness of the Nosocomial Transmission Group, and the actions taken by that group in respect of the guidance provided to hospitals and other health and care settings, the monitoring arrangements put in place to ensure effective implementation of that guidance, and the lessons learned by the Welsh Government. The internal audit service provided substantial assurance on the controls in place in respect of the Nosocomial Transmission Group. I produce here, a copy of this report, as exhibit **M3CNOW01/168-INQ000022598**.

337. To the best of my knowledge, there were no occasions where the advice of the Nosocomial Transmission Group was not followed by the Welsh Government, or any health or care bodies or organisations in Wales.

Involvement in the formulation of guidance or advice relating to visiting restrictions in hospitals

Jean White

338. Through my discussions with the Nurse Directors during this initial phase of the pandemic, it became apparent that there was a need for national guidance on the restriction of hospital visiting to ensure a consistent approach across Wales. I produce here minutes of my meeting with the Nurse Directors on 18 March 2020, as previously exhibited at **M3CNOW01/07–INQ000299025**. I checked with the other UK CNOs to understand what their approach was and developed guidance for NHS Wales that aligned with other parts of the UK. I did not do this lightly as I was acutely aware that I would be restricting access of family and friends to their loved ones who were in-patients. However, reducing the risk of spreading the infection to other patients, staff, and members of the visiting public, a situation that carried the real potential to cause significant harm, had to take precedence. I issued a letter to the Nurse Directors on 25 March 2020, asking that they restrict visiting to inpatients not suffering from Covid 19 infection with three exceptions: permitting one parent or guardian to be with a paediatric (child) or neonatal (new-born baby) in-patient;

women in labour to have one birthing partner from their household; and, with the advance agreement of the ward sister/ward manager, patients receiving end of life care could have one visitor for an agreed amount of time. Visiting to patients infected with Covid 19 was only to be undertaken in exceptional circumstances. This letter and subsequent letters and guidance made it clear that enabling people to say goodbye to loved ones at the end of their lives was to be facilitated wherever possible, and appropriate personal protective equipment ("PPE") should be provided for visitors to ensure their safety. I advised that pregnant women and people who had underlying health conditions that put them at greater risk from the Covid-19 virus should be encouraged not to visit. I produce here as exhibit **M3CNOW01/169–INQ000399385**[4], the letter that I sent to Nurse Directors on 25 March 2020 providing guidance on hospital visiting.

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

340. 20 April 2020: Letter from the CNO(W) to NHS Wales chief executives and Nurse Directors amending the restrictions with immediate effect to also provide an exception for someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient/service user to be distressed. I produce the letter here as exhibit **M3CNOW01/170–INQ000299228**.

341. 15 July 2020: Letter from the CNO(W) to chief executives, Nurse Directors and heads of midwifery in NHS Wales providing greater flexibility to local health boards and NHS trusts with effect from 20 July 2020, which I produce here as exhibit **M3CNOW01/171–INQ000299515** together with an accompanying annex called

---

[4] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000299068]*

"Hospital Visiting during Coronavirus Outbreak: Guidance", which I previously exhibited as **M3CNOW01/069a – INQ000299514.**

342. 13 November 2020: Letter from the CNO(W) to chief executives, executive directors of nursing, directors of therapies and healthcare scientists, NHS clinical directors, heads of midwifery, heads of sonography/radiotherapy services, and hospices in Wales, updating the instructions issued in July 2020 and adding a methodology for risk assessment with effect from 30 November 2020. I produce here, as exhibit **M3CNOW01/173–INQ000299694**, a copy of the letter, and as exhibit **M3CNOW01/174-INQ000081643**, a copy of the risk assessment.

343. The Minister made a statement on 30 November 2020 to alert Members of the Senedd and the public to the most recent changes to the guidance, which I previously produce as exhibit **M3CNOW01/029–INQ000300096**.

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

345. On 8 April 2020, changes were introduced into the NHS England hospital visiting guidance, which I produce here as exhibit **M3CNOW01/176–INQ000300097**. They had added one additional situation to the three exceptions to restricting visiting to non-Covid-19 patients. The following addition was made: "someone with a mental

health issue such as dementia, a learning disability or autism, where not being present would cause the patient/service user to be distressed". This seemed an important addition to make to the guidance in Wales too and, therefore, I issued an update to the guidance on 20 April 2020. I reiterated in my letter that wherever possible family members and loved ones were to be enabled to say goodbye to Covid-19 infected patients receiving end of life care. I remained acutely aware of the impact this was having on patients and their families and loved ones, but I remained of the opinion that in the absence of a vaccine, minimising the risk of cross infection was paramount. At the Nurse Directors meeting of 19 May 2020, the Nurse Directors were asked to ensure that staff, and members of the public, were aware of these changes to the guidance. The minutes of the meeting of 19 May 2020 were previously exhibited at **M3CNOW01/120- INQ000412515**.

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

347. The July 2020 guidance had an annex 2 that set out specific considerations for pregnant women and their partners visiting maternity services, including the antenatal scans and checks done at: 12 weeks pregnancy dating scan, early pregnancy clinic, anomaly scan, and attendance at a Fetal Medicine Department. This guidance had been developed following multiple correspondences from the public and Members of the Senedd, on behalf of their constituents, strongly requesting that partners should be present with the pregnant woman. After this

guidance was issued, I received feedback from the sonographers and radiographers, who undertake the antenatal scans, raising concerns about the practical application of this guidance to their physical environments. Their concerns were that the rooms used for scans are typically small with limited ventilation, and consequently maintaining 2 metres distance from anyone accompanying the pregnant woman would be impossible. Additionally, waiting rooms could easily become full if additional people attended with the pregnant woman, again making social distancing difficult. They also did not feel they had been consulted sufficiently before this new guidance was issued. I held a meeting with representatives on 5 August 2020 to agree a way forward, and I previously produced the minutes of this meeting as exhibit **M3CNOW01/070–INQ000300098**. It was agreed that a risk-based approach would be applied locally in order to ensure everyone's safety.

348. During the autumn months the infection rates again began to increase within communities in Wales, leading to a two-week firebreak lockdown from 23 October to 9 November 2020. When the First Minister announced this lockdown, he also said that there would be a new simpler set of rules from 9 November 2020 onwards, set out under the Health Protection (Coronavirus Restrictions) (Number 4) (Wales) Regulations 2020. Even with increasing community transmission it was still felt important to allow NHS organisations to have flexibility in determining who had access to their premises. In the Nurse Directors meeting of 25 September 2020, it was noted that the next review of the hospital visiting guidance would need to consider local need rather than following a national "one size fits all" approach. I exhibit a copy of the minutes from 25 September 2020 at **M3CNOW01/178-INQ000421009.** Everyone was aware of the negative impact restricting visiting was having on in-patients and therefore no one wished to increase restrictions unless it was deemed essential in specific clinical areas to do so. As a consequence, a further revision of the national guidance for hospital visiting was undertaken that was issued on 13 November 2020 and came into force on 30 November 2020. This guidance, previously exhibited in **M3CNOW01/173–INQ000299694**, made reference to the risk-based approach, agreed with the radiographers and sonographers in NHS Wales, that was being applied locally to support pregnant women throughout their

pregnancy journey. The guidance also provided a weblink to the joint Royal College of Obstetricians and Gynaecologists and Royal College of Midwives guidance "Reintroduction of visitors to maternity units across the UK during the Covid-19 pandemic" issued on 8 September 2020, to assist in understanding how a risk assessed approach to visiting could be undertaken. The November 2020 guidance was accompanied by a written statement by the Minister for Health and Social Services, previously exhibited in **M3CNOW01/029–INQ000300096**, that described the approach being implemented. It was felt this was important to do given the number of letters of concern that had been made by the public and some sections of the health service asking for changes or information. The guidance was published on the Welsh Government's website.

349. In terms of issues raised to me about visiting restrictions, I was acutely aware throughout my tenure as CNO that any restrictions placed on visiting patients had the potential to generate concern amongst the public. This was also highlighted to me during the meetings of the Nurse Directors such as in the meeting of 25 September 2020 in which it was noted that restrictions in maternity services seem to cause the most correspondence with the public and in the meeting of 20 November 2020 which noted that negative feedback had been received in relation to end of life care and visiting rules. The minutes of those meetings were previously exhibited at **M3CNOW01/178-INQ000421009** and **M3CNOW01/102-INQ000412577** respectively. Further information around concerns about visiting restrictions in maternity services is also set out at paragraphs 426-431 of this statement. However, as I have noted above, reducing the risk of spreading infection to patients was of upmost importance in making decisions around restrictions to visiting and I tried to always ensure that the significance of that was clearly stated in any public messaging.

Gareth Howells

Changes to hospital visiting arrangements, June 2021

350. While it was clear that Covid-19 had not gone away, and we remained cautious about the impact of the Delta variant on health and care services, by this time it was clear that different parts of Wales were experiencing different Covid-19 transmission and infection rates at different times.

351. Our absolute priority remained keeping people safe, but we also needed to maintain a balance between protecting people from the virus on one hand, and supporting the wellbeing of patients and their loved ones on the other.

352. Restrictions on visiting had a huge impact on patients and their loved ones, and the Welsh Government was keen to support health boards to make changes to hospital visiting arrangements, by providing them with further flexibility to allow visiting to be "opened up", dependent upon local conditions and a careful assessment of risk. The challenges surrounding visiting, and particularly a lack of consistency in the interpretation of guidance across Health Boards, was highlighted to me in the meeting of the Nurse Directors on 16 April 2021. I confirmed to the Directors of Nursing that it was important that the CNO is kept updated on that and that further support will be needed from the Welsh Government in allowing visiting to be opened up across the country. The minutes for the meeting on 16 April 2021 were previously exhibited at **M3CNOW01/125-INQ000412589.**

353. The revised hospital visiting guidance, published on 18 June 2021, therefore set out the baseline for hospital visiting in Wales during the pandemic, but allowed health providers to depart from the guidance in response to rising or falling levels of Covid-19 transmission in their areas.

354. In doing so ,however, there had to be a focus on ensuring any changes were risk assessed, and the need to maintain a close link with Public Health Wales when making decisions, to be clear about local community transmission rate, variants of concern, the vulnerability of particular patient groups, and individual circumstances.

355. The revised guidance included the option for health boards and NHS trusts to use lateral flow testing, or point of care testing, to support hospital visiting. It also made testing available for parents of children in hospital, pregnant women and their identified support partner and/or essential support assistants in maternity services. Subject to local determination and following a risk assessment, it also allowed up to two parents, guardians or carers at a time to visit a child in a paediatric inpatient ward or a baby in neonatal care. These recommendations were agreed and ratified by the All Wales Maternity and Neonatal Network Board.

356. I produce here the following exhibits in relation to the above: -

a. **M3CNOW01/182 – INQ000103976**: the advice provided to the Minister for Health and Social Services.

b. **M3CNOW01/183 – INQ000271666**: the Minister's response to that advice.

c. **M3CNOW01/184 – INQ000271664**: the updated guidance on hospital visiting.

d. **INQ000116711– INQ000271665**: the written statement issued by the Minister.

e. **M3CNOW01/186 – INQ000271668**: my covering letter to NHS Wales chief executives, clinical directors, executive nurse directors, heads of midwifery services, heads of therapies and healthcare science, heads of sonography / radiography services, hospices in Wales, the Wales Maternity and Neonatal Network Board, and the Royal College of Paediatrics and Child Health.

Sue Tranka

357. I played no role in the formulation of guidance and/or advice in Wales in relation to the introduction or lifting of visiting restrictions in hospitals, which occurred prior to my taking up the post of CNO. I did however provide advice to the Minister for Health

and Social Services on 1 December 2021 seeking approval to the "Hospital Visiting During Coronavirus Guidance: Supplementary Statement" acknowledging that Health Boards, Trusts and Hospices were able to restrict visiting and accompanying of patients to scheduled and unscheduled appointments for the purposes of infection prevention and control in response to risks posed by other infectious diseases, and to recognise that the decision making process with regard to visiting in a health care setting during the pandemic may be multi-factorial. The advice, which was accepted, was previously exhibited in **M3CNOW01/22-INQ000116711** at paragraph 98 above.

Risk Assessments

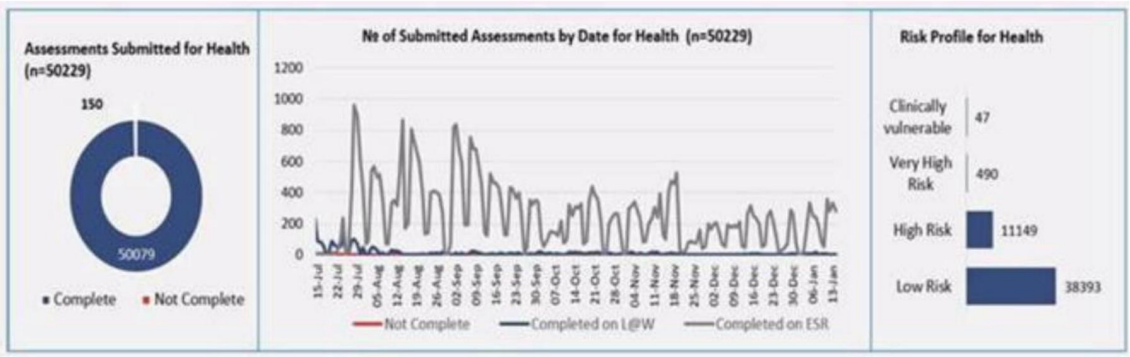
Jean White

358. Early in the pandemic the First Minister launched an urgent investigation to understand the reasons for the higher risk to Black, Asian and Minority Ethnic communities and established an expert advisory group. On of the subgroups focused on risk assessments and was chaired by Professor Keshav Singhal. It led on the development of an All-Wales Covid-19 Risk Assessment Tool ('the Tool') which was the primary method for risk assessments within the NHS and Social Care Sectors. The aim of the Tool was to both understand and reduce the risk for all staff, but particularly Black, Asian, and Minority Ethnic staff. I exhibited a copy of the Tool at **M3CNOW01/13 – INQ000299409**. The tool was implemented in May 2020 across the NHS in Wales. I was aware of this tool and its use within the clinical setting. Indeed, in July 2020 I sent an email responding to an issue of the spread of Covid infection at Llandough hospital in which I reinforced the need to use the staff Tool and social distancing. I have exhibited the email dated 6 July 2020 at **M3CNOW01/187 – INQ000412525**.

359. I was also aware of the need to amend the Tool in December 2020 when clinically extremely vulnerable staff were advised to return to shielding. The advice to 'stay at home' meant that the Tool was amended so as not to be inconsistent with guidance. I was copied into the communication discussing appropriate amendments and I was grateful for the guidance as I had received numerous emails from concerned Nurse

Directors about how it would impact their staff. I exhibit a copy of an email dated 23 December 2020 at **M3CNOW01/189-INQ000412533** in which I raised the concerns from Nurse Directors. The Unions position however was that the clinically extremely vulnerable should have just been told to stay at home. Ultimately the matter was dealt with by the Minister for Health and Social Services and he left it to the individual to determine how the shielding advice applied to their own particular circumstances. I exhibit a copy of an email dated 24 December 2020 at **M3CNOW01/190-INQ000412534** indicating that the Minister was content for the individual to determine how the shielding advice applies to their own particular circumstances. Notwithstanding this difficulty the Tool was an essential asset in the protection of healthcare and social care staff and was widely used.

360. In February 2021, I was copied into an email chain referencing an article which highlighted concerns in England that one-in-five Black, Asian and Minority Ethnic clinicians had not been risk assessed by their trust during the pandemic. In response, Welsh Government colleagues from the Workforce and Organisational Development Directorate referred to data collated from Local Health Boards which showed that that in Wales, as of 14th January 2021, more than 50,000 health staff had completed the Tool and more than 50,000 users had downloaded the paper version. In addition, Workforce and Organisational Development Directorate had confirmed that all Black, Asian and Minority Ethnic staff had been risk assessed. I exhibit the email exchange at **M3CNOW01/191 – INQ000412543**. It includes the following graph which shows a breakdown of the completed risk assessments by risk profile, with the vast majority (38,393) being low risk.



361. I was not involved in the formation of the Tool or occupational risk assessments more generally as this was co-ordinated by the risk assessment sub-group.

362. In terms of my other involvement in ensuring Covid-19 specific risk assessments were undertaken, in early January 2021 I was at the forefront of ensuring that overseas trained nurses who were added to the NMC Temporary Register were appropriately risk assessed by their employer. I was at pains to ensure that the requirement to risk assess these workers was clear, particularly given that most were from Black, Asian and Minority Ethnic groups and that all employers recruiting workers via this route were aware of the All-Wales Covid-19 Risk Assessment Tool. I exhibit a copy of an email dated 4 January 2021 **M3CNOW01/192-INQ000412535** in which I noted the importance of the Tool.

363. Another significant involvement that I had in respect of risk assessments during the pandemic was regarding guidance for the use of PPE and non-CE marked PPE. In respect of the former, on 1 April 2020 I, alongside the other nations CNOs and the four nation CMOs, agreed guidance on the use of PPE for health and social care. The guidance was endorsed by professional bodies and the WHO. The guidance was issued to assist occupational risk assessment for when and in what circumstances PPE should be used. However, because of a lack of availability of CE marked PPE, both locally and nationally, Local Health Boards needed to make appropriate provision.

364. The general instruction to all Local Health Boards was that staff should use CE marked PPE as this complies with the Personal Protective Equipment Regulations 2002. However, if this was not available then a flow-chart of actions was implemented to overcome the highlighted risk. This was exemplified in the documents produced by Swansea Bay University Health Board of which I was aware and requested. I exhibit an email dated 24 April 2020 from Gareth Howells (who was at Swansea Bay University Health Board) at **M3CNOW01/193-INQ000412500** and the document published by Swansea Bay University Health Board entitled "Process for Using PPE which is not CE marked during Covid-19 Pandemic" at **M3CNOW01/194-**

INQ000412501. Additionally, the CMO and I had to agree the use of PPE in cardiopulmonary resuscitation as there were concerns expressed by Nurse Directors about the different guidelines. It was agreed in a meeting on the 8 April 2020 that I would notify Nurse Directors that PPE should be worn in acute settings and in respect of community settings the current UK guidance would apply. I exhibit a note of the teleconference between myself, Gill Richardson, Frank Atherton dated 8 April 2020 at **M3CNOW01/195-INQ000384253**.

Gareth Howells and Sue Tranka

365. As CNO we played no role in ensuring that risk assessments were undertaken by employers for nursing or midwifery staff, nor in producing or disseminating guidance, at a national or local level, on occupational risk assessments, nor were we made aware of any issues or concerns regarding regional variations.

The decision to suspend inspection of healthcare settings by Healthcare Inspectorate Wales

Jean White, Gareth Howells and Sue Tranka

366. As CNOs, we played no role in providing advice to Welsh Ministers nor did we have any other involvement in any decision to suspend inspection of healthcare settings by Healthcare Inspectorate Wales (HIW). For completeness, we note that HIW attended meetings of the Nosocomial Transmission Group from September 2020 (after the decision to suspend inspection).

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

Involvement in DNACPR guidance

Jean White

367. On 12 April 2020, the Chief Medical Officer and I issued a joint letter to NHS Wales informing them of the publication of a new framework of values and principles for

healthcare delivery in Wales, to provide guidance for healthcare services when making decisions during the coronavirus outbreak that arose from the work of the Covid-19 Moral and Ethical Guidance Group Wales (CMEAG-Wales). I produce here a copy of my letter with the CMO, as previously exhibited at **M3CNOW01/061–INQ000300105** and a copy of the framework entitled "Coronavirus: ethical values and principles for healthcare delivery framework" dated 12 April 2020 as exhibited **M3CNOW01/062–INQ000081000**.

368. The CMO(W) and I issued further guidance on 17 April 2020 reminding clinicians that Do Not Attempt Cardiopulmonary Resuscitate ("DNACPR") decisions must be made on an individual basis. Age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes. I produce here, as previously exhibited in Exhibit **M3CNOW01/063–INQ000300106**, a copy of that letter.

Gareth Howells and Sue Tranka

369. We have had no involvement in DNACPR guidance in our tenures as CNO.

Awareness of any concerns relating to the blanket use of DNACPR notices

Jean White

370. In April 2020, the CMO and I were made aware of concerns from the groups advocating for disabled and learning disability communities in Wales about how the Clinical Frailty Scale (which is described in further detail in the following section) could be used inappropriately in making decisions on escalation of care and DNACPR for individuals being treated for Covid 19. Concerns were also raised by the Older People's Commissioner ('OPC') about the care and treatment options that would be available to older and vulnerable people, some of who had felt pressurised into signing DNACPR forms.

371. We wrote to Health Board Chief Executives, Medical Directors, Directors of Nursing and Directors of Therapies and Healthcare Scientists on 17 April 2020 to

highlight these concerns. The letter, as previously exhibited in **M3CNOW01/063–INQ000300106**, noted that while we were not aware that DNACPR decisions were being made purely on the basis of an individual's age, having a disability, learning disability, autism, mental illness or other condition, it was important to reiterate that:

a. Age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes.

b. It remains essential that decisions are made on an individual and consultative basis with people. It is unacceptable for advance care plans, with or without DNACPR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need and individual wishes.

c. NICE guidelines specifically advises that the Clinical Frailty Scale (CFS) is not validated in, and should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disabilities or autism. An individualised assessment is recommended in all cases to consider comorbidities and underlying health conditions.

372. On 13 February 2021, it was reported in the media that DNACPR notices were being issued to COVID-19 patients with learning disabilities in England. Queries from Members of the Senedd noted a number of constituents found this distressful and were seeking clarification of the policy for Wales. We anticipated that the health care bodies in Wales may have similar queries so the CMO and I wrote on 10 March 2021 to highlight what we had said in our 17 April 2020 letter to the same recipients again and to confirm that this remained the Welsh Government position, applicable to all patients regardless of whether they have COVID-19 or not. We asked for the contents of the letter to be shared with all relevant staff. The 10 March 2021 letter is exhibited in **M3CNOW01/196-INQ000227370.**

Gareth Howells

373. I was not aware of any concerns raised regarding the use of DNACPR notices during my tenure as CNO.

Sue Tranka

374. On 14 April 2022, the CMO and I wrote a joint letter to Health Board Chief Executives after being made aware of a report made to the Learning Disability Ministerial Advisory Group of an instance of a decision to issue a DNACPR notice for an individual on the basis of a learning disability. Our letter, exhibited in **M3CNOW01/197-INQ000412593** references the letters sent by the CMO and CNO Jean White on 17 April 2020, previously exhibited in **M3CNOW01/063-INQ000300106** and 10 March 2021 as previously exhibited in **M3CNOW01/196-INQ000227370** and sought assurance that DNACPR decisions were not being made purely on the basis of an individual's age, having a disability, learning disability, autism, mental illness or other condition. The letter noted that while this may have been an isolated incident, one was one too many. We requested, as a matter of urgency, written confirmation of the governance and assurance processes in place within each Local Health Board to ensure these decisions were taken in line with extant clinical guidance. To the best of my recollection, responses were received from Local Health Boards and no significant concerns arose. However, in preparing this statement we have been unable to confirm that every Local Health Board responded in writing. We also wrote to the Academy of Medical Royal Colleges Wales seeking their support to spread this message across their member colleges.

The Clinical Frailty Scale

Jean White, Gareth Howells and Sue Tranka

375. Frailty is a long-term condition associated with ageing and characterised by loss of function and resilience affecting an individual's ability to 'bounce back' from changes in personal and social circumstances or from illness, including relatively

minor illness. Frailty is individual and varies significantly amongst people. It outlines a state of increased vulnerability and can be measure and scaled.

376. The Clinical Frailty Scale (CFS) is a judgment-based tool used globally which evolved from The Canadian Study of Health and Ageing. The CFS uses a nine-point scale, and the severity of frailty increases with each numbered level – the scale ranges from 1 (very fit) to 9 (terminally ill). It was last updated in September 2020 by the authors of the original Canadian study, with minor labelling changes, for example level 4 of the scale was updated from 'mildly frail to 'living with mild frailty'. The CFS is an intuitive tool that can be used across health and social care and is heavily weighted to evaluate a person's functional ability, including the ability to mobilize and perform activities of daily living (washing, dressing etc). There is also a visual chart to assist with the frailty classification. The CFS is therefore used to identify, evaluate, and quantify levels of frailty based on the functional ability of individuals.

377. Identifying and measuring levels of frailty helps identify those people/patients at risk of adverse outcomes due to frailty and enables proactive care to maximise outcomes for people. It supports clinical decisions and care planning to enable the right resources, treatments, and interventions to be targeted in a timely way where they will have the most impact.

378. The CFS is only validated for use in those 65 years or older. It has not been validated for people with learning disability and may not perform as well in people with stable long-term disability such as cerebral palsy, whose outcomes might be very different compared to older people with progressive disability. It is advised that the CFS is not used in these groups.

379. The CFS was used in every Local Health Board in Wales but it was not generally embedded or systematically used in nurses' day to day practice in Wales during the relevant period: it was not part of the routine suite of assessments undertaken by nurses and there was no requirement for any clinicians to systematically or routinely identify and assess frailty. Nurses working in community settings were aware of the CFS as a result of the Covid-19 Primary and Community Care Guideline (also

referred to as 'Framework') issued by the Welsh Government on 23 March 2020, exhibited in exhibit **M3CNO01/200- INQ000226967**. The Framework outlined the four key health care actions in the community as

i. Self-care and self-management at home.

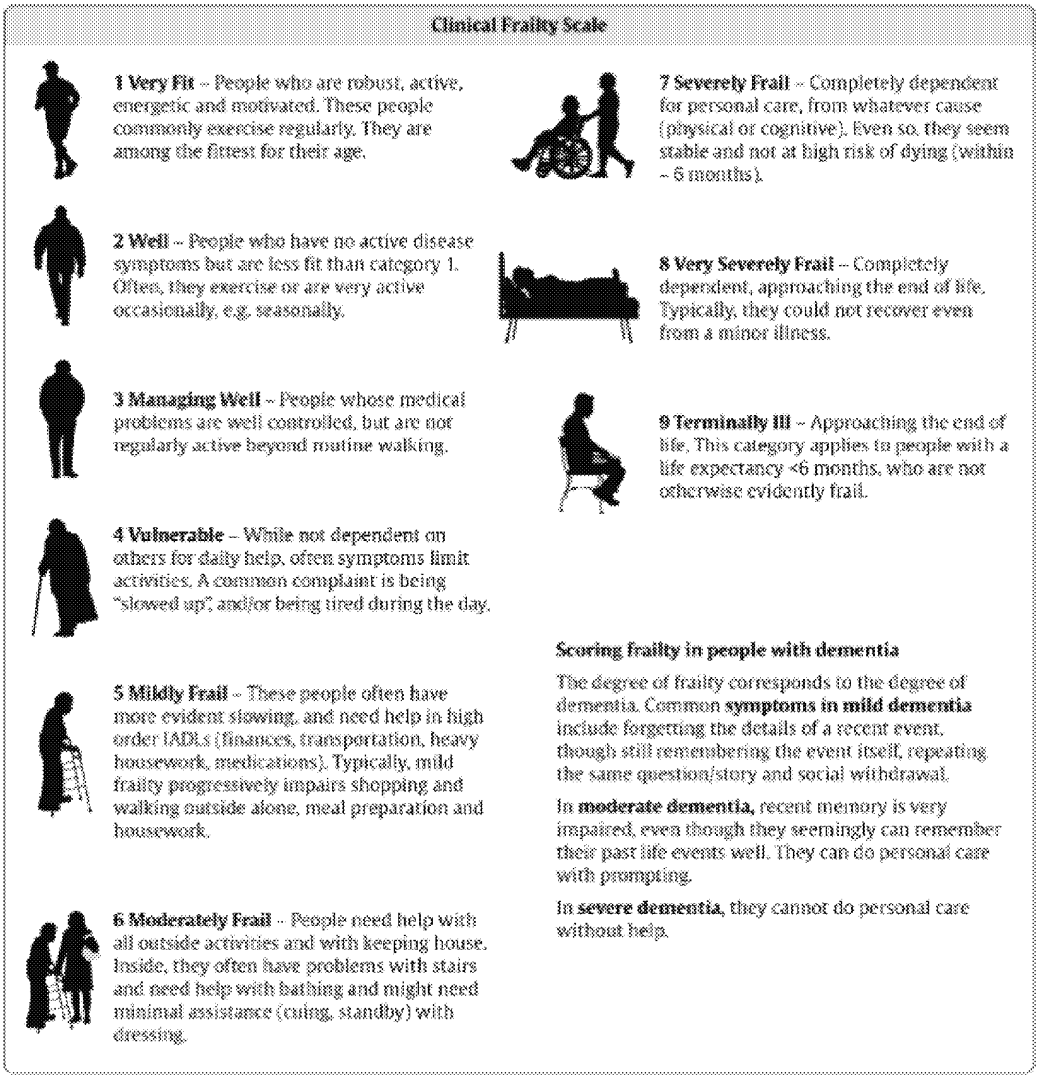
ii. Supportive care delivered in the home, GP surgery or cluster hub by a multi-professional team serving a cluster population.

iii. Palliative care delivered in the home.

iv. Referral to an acute hospital.

380. The Framework also included a section covering an ethical framework to apply when considering whether a patient requires admission. This stated that treatments should be used that work, without disproportionate harm, subject to consent or best interest judgments, and provided they can be offered within the resources available. Treatments should not be used where they do not meet these criteria, nor where they stand no real chance of working in a particular patient. It emphasised that whatever treatment was being used, each patient should be given the best care available, helping them to survive if that can be achieved and, in all cases, helping them to be comfortable and live with dignity. It noted that making sure patients are not given treatments which are not right for them helps them, and also helps other patients who may have a greater chance to have treatments that work: this should be the basis of decision and is the fairest way to decide when there is not enough to go around.

381. The Framework included a visual guide to the Clinical Frailty Scale, reproduced below. However, as there is no national electronic clinical record in community settings, the extent to which the CFS was used is unclear.



Advice or guidance regarding the use of the Clinical Frailty Scale

Jean White

382. On 9 April 2020 I emailed the CMO suggesting that Wales should issue guidance, similar to that which had been issued in England, that the Clinical Frailty Scale should not be used in younger people, people with stable long-term disabilities, learning disability or autism and that an individual assessment be recommended in all cases where the CFS is not appropriate. I exhibit the email I sent dated 9 April 2020 at **M3CNOW01/201-INQ000412488** in which I suggested that guidance should be

issued and a letter dated 3 April 2020 from Claire Murdoch, the National Mental Health Director, at **M3CNOW01/202-INQ000412489** clarifying the position on the use of the Clinical Frailty Scale and the use of DNACPR with younger patients, those with stable long-term disability or autism.

383. On 14 April 2020 the Welsh Critical Care and Trauma Network and the Welsh Intensive Care Society issued all Wales guidance to help clinicians make a more informed assessment of clinical suitability / risk for patients. It stated that Clinical Frailty Scoring is not validated for use in patients under the age of 65 and should otherwise be used with great caution, The guidance is exhibited at **M3CNOW01/203-INQ000412497**. University Health Boards were well aware that the Clinical Frailty Scale was commonly used as a triage tool to make clinical decisions and were proactive in issuing guidance and advice, including to care homes at the point of discharge, on the correct use of CFS. This included that CFS is not validated in people under 65 or those with stable disabilities. There was also clinical guidance issued by the Intensive Care Society and endorsed by the Welsh Intensive Care Society which set out some important caveats to the use of Clinical Frailty indices. It stated that frailty assessments should not be routinely used to assess patients who may have good biological reserve to recover from acute illness and have stable physical or learning disabilities.

384. I was content that there was an abundance of guidance and knowledge amongst health care practitioners in relation to the appropriate use of the CFS. However, in the letter dated 17 April 2020, previously exhibited in **M3CNOW01/063–INQ000300106**, the CMO and I wrote to all Health Boards following concerns that had been raised about how the Clinical Frailty Scale could be used inappropriately in making decisions on escalation of care and DNACPR for individuals being treated for Covid 19. These concerns had been raised with the policy lead for learning disabilities, NR who has since sadly passed away. Our 17 April 2020 letter stated that age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order and that CFS is not validated in, and should not

be used, in younger people, people with stable long-term disabilities, learning disabilities or autism. An individualised assessment was recommended in all cases.

Gareth Howells

385. I had no involvement in relation to CFS guidance or advice.

Sue Tranka

386. I did not produce any advice or guidance regarding the use of the CFS during the relevant period.

387. In January 2023 (outside the relevant period), the National Community Nursing Specification sets out the aspiration to introduce and routinely capture and use CFS. Health boards are now in the process of introducing this, and the Strategic Programme for Primary Care are monitoring the progress. This suggests that it was not universally used across community nursing prior to this date and still may not be.

Awareness of any concerns relating to the use of the Clinical Frailty Scale

Jean White

388. In paragraphs 370-371 and 388 above, I have described concerns raised regarding the CFS in relation to DNACPR notices and the letter I issued in response.

Gareth Howells

389. I was not made aware of any concerns relating to the use of the CFS during my role as CNO.

Sue Tranka

390. I was not made aware of any concerns relating to the use of the CFS during the relevant period.

Maternity services

Jean White, Gareth Howells and Sue Tranka

391. Within the Chief Nursing Officer team there is a dedicated Nursing Officer for Maternity Services and Early Years. At the start of the pandemic this was NR NR continued in this post until September 2021 when she was appointed as Chief Midwifery Officer for Wales, a post in which she continues today. NR Jewell has assisted with the following section given her responsibilities and role during the relevant period.

Suspension or reduction of Maternity Services in Wales

Jean White, Gareth Howells and Sue Tranka

392. Maternity Services were classed by the Welsh Government and NHS in Wales as Essential Services. This was set out in the Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID 19 Pandemic, as exhibited in exhibit **M3CNOW01/204-INQ000231281**. This Framework broadly defined Essential Services as services that are life-saving or life impacting, i.e. where harm would be significant and irreversible without urgent or emergency intervention. These included, among other things, maternity services including antenatal screening and neonatal services including transport.

393. The Welsh Government's expectation from start of the pandemic was that all health boards continued to offer choice of place of birth choice to mothers. Where this was not possible due to staffing pressures some health boards had to suspend or centralise services.

394. The Chief Nursing Officer was usually notified prior to decisions being implemented to suspend maternity services or where services were being centralised. Notification was provided informally by a local health board's Head of Midwifery or Director of Nursing, however there were times when this was not

possible as a service closure was at pace and in response to high acuity and low staffing numbers.

395. Suspensions once made were reported through the formal No Surprise system (Early Warning Notice) which would describe the situation, the action taken and plans for restitution if known. Local health board are required to report No Surprises, through an agreed internal process, to Welsh Government as outlined within guidance issued in in February 2014, 'Putting Things Right'. For ease of reference, 'No Surprises' reporting requires health boards or trusts to report 'sensitive' issues to Welsh Government. Such issues may include incidents or events which could lead to adverse media attention, temporary capacity issues or incidents where it is initially unclear whether a serious incident has occurred.

396. A copy of the No Surprise Notifications covering the relevant period is exhibited in **M3CNOW01/205-INQ000412561.** The following No Surprises Notifications relating to suspension or centralisation of Maternity Services were received during the relevant period:

    a. On 1 October 2020 Test Trace Protect informed the maternity services in Singleton Hospital, which is part of Swansea Bay University Health Board that 2 support staff who had tested positive for Covid 19.

    b. 11 January 2021 the Maternity and Neonatal Unit in the Princess of Wales Hospital, part of Cwm Taf Morgannwg University Health Board, closed for 6 hours due to positive Covid 19 mother who had been present on the Neonatal Unit and post-natal ward. The consequence resulted in the remaining babies on Neonatal Unit being isolated to ensure that safe distancing measures were in place. Acuity on the unit at the time was 2 High Dependency Unit babies and 5 special care babies. The unit was unable to accommodate any further admissions during this period.

c. Swansea Bay UHB maternity service reported on 9 July 2021 Midwifery staffing unavailability levels over 30%. This is due to a number of factors including;

   i. Covid shielding due to medical issues

   ii. Covid shielding for pregnant midwives from 28/40 gestation

   iii. Self-isolation due to Covid contact

   iv. Increased short term and long term sickness levels

   v. Increased number of midwives on maternity leave.

d. An update to this No Surprises notification was made on 15 September 2021 noting that community midwifery staffing levels remain critical at 32% and there was a temporary suspension of maternity services at the Freestanding Midwife Unit (FMU) in Neath Port Talbot hospital. The Freestanding Midwife Unit status was reviewed weekly.

e. On the 5 October the health board maternity service updated that the midwifery staffing critical levels increased from previously reported 32% to 37% and that actions have been taken to centralise and base the management team, community & birth centre midwifery team, and specialist midwives at Singleton Hospital to ensure safe delivery of care and deployment of staff.

f. Cardiff and Vale UHB on 18 August 2021 reported unprecedented challenges within the maternity service. This was recorded as due to a combination of the volume and complexity of cases, rising Covid-19 positive patients and continued staffing constraints.

g. Cardiff and Vale UHB reported on 24 March 2022 that due to increased staffing constraints from significant short-term sickness in the Maternity

Department, the Midwifery Led Unit was closed on 19 March 2022 and the Homebirth Service suspended.

397. Any suspension of a service would be reviewed through the weekly Sitrep meeting attended by the Nursing Officer for Maternity and through the weekly Nurse Director meeting or informally by the Director of Nursing or Head of Midwifery.

398. In terms of the impact of suspensions on a pregnant woman's choice as to where to give birth, local health boards had a responsibility for providing information to women on changes to service provision and there was an expectation that women were provided with the same care pathway but in a different location.

399. The maternity and neonatal network co-ordinated weekly meetings with representatives from each health board which enabled concerns or issues to be escalated nationally as needed. In terms of any concerns regarding the suspension of services there were no specific concerns raised during the relevant period to any of the three Chief Nursing Officers, however a detailed summary of concerns relating to maternity services is provided below at paragraphs 424-441.

400. As noted above, services needed to be centralised at times of peak acuity and low staff numbers at some health boards, which impacted on the choice of place of birth. However, care pathways remained the same. The policy was that screening, scans and appointment schedules continued in accordance with pre-Pandemic standards, as set out in established NICE guidelines, and that there was no alteration to the frequency of universal care points.

Guidance on access for partners and visitors

Jean White, Gareth Howells and Sue Tranka

401. Development and consultation of maternity visiting guidance was delegated to Nursing Officer Maternity and Early Years, however overall signoff remained with the Chief Nursing Officer. Information was shared at a UK level by Chief Nursing Officer's attendance at weekly UK health leads meetings.

Jean White

402. I wrote to the NHS Wales Nurse Directors on 25 March 2020, as previously exhibited in **M3CNOW01/169** **INQ000399385** In this letter I set out advice on restricting visitors to in-patient healthcare settings at this time following the UK wide national lockdown announced on 23 March 2020. I noted that in normal circumstances, the Welsh Government supports a person-centred flexible approach to visiting so patients and service users can see their families and loved ones, however, this was not normal circumstances and we needed to ensure the safety of patients, service users, staff, and visitors themselves where possible. Consequently, I advised that all visiting was suspended. I highlighted that there may need to be some exceptions to this general advice and that visiting patients not infected with COVID-19 should be permitted for:

a. One parent or guardian for paediatric inpatients and neonates.

b. People receiving end of life care, with permission to visit secured in advance from the ward sister/charge nurse and if agreed, this should be one visitor at a time for a specified amount of time; and

c. Women in labour should be permitted a birthing partner from their household.

403. On 20 April 2020, this guidance was updated by letter, as previously exhibited in **M3CNOW01/170-INQ000299228**. The letter noted that on 8 April, NHS England added an additional category of patients/service users to their visitor guidance, which I felt should be included in the above list and applied to NHS Wales: someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient/service user to be distressed.

404. This advice was included and updated on the 20 July 2020, in the 'Hospital visiting during the Coronavirus outbreak: guidance', as previously exhibited in **M3CNOW01/069a-INQ000299514.** The Nursing Officer for Maternity and Early Years contributed to the maternity sections of this Guidance, which I signed off as

Chief Nursing Officer. The guidance confirmed that in addition to having a partner in labour this revised guidance was applicable to women when attending the maternity hospital for the following reasons:

a. 12-week pregnancy dating scan

b. early pregnancy clinic

c. anomaly scan

d. attendance at Fetal Medicine Department;

405. The guidance stated "Women can be accompanied by their partner or nominated other, preferably from the same household or part of an extended household, to any of the above except in outbreaks of the COVID-19 pandemic in a hospital setting. There may be occasions in individual health boards that visiting, for specific reasons, may be limited further than outlined in this guidance. This will most likely be to reduce the number of people in any one area to comply with social distancing rules."

406. An update to this guidance was issued on 30 November 2020, as previously exhibited in **M3CNOW01/174-INQ000081643**. As before, my Nursing Officer for Maternity and Early Years contributed to the maternity sections of this guidance, which I signed off as Chief Nursing Officer. The updated guidance included at Annex 2 a framework to assist health boards to assess visitor access for partners, visitors and other supporters of pregnant women in maternity services during the Covid-19 pandemic. The framework was informed by the guidance provided to NHS England from the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG) and the subsequent published framework by NHSE (September 2020).

407. The framework recommended health boards undertake a risk assessed approach to either relax or restrict visiting according to local transmission of Covid-19, in collaboration with relevant health professionals, local infection prevention and control teams and Public Health Wales.

408. The guidance anticipated that risk levels would be set predominately by following the overall health board's risk levels. However, localised risk assessments were also able to be undertaken for individual maternity units / services. Based on the risk rating different levels of restrictions of partners, visitors or supporters applied, as set out in the below table taken from the Guidance at Annex 2 and reproduced below.

Assessing restrictions of partners, visitors or other supporters to maternity inpatient services

Risk Rating	**Labour and Birth Settings**	**Antenatal or Postnatal Inpatient settings**	**Maternity Outpatients**	**Ultrasound Appointments**
Very High	Essential support assistant AND / OR a single birth partner in active labour	Women to attend appointments alone. However essential support assistants able to attend to provide specified support. One nominated adult may accompany the woman attending where she requires familiar support for consultations which may cause her distress	Women to attend appointments alone. However essential support assistants able to attend to provide specified support. One nominated adult may accompany the woman attending where she requires familiar support for consultations	All scans: Women to attend scans alone. However essential support assistants able to attend to provide specified support. One nominated adult may accompany the woman attending where she

			which may cause her distress	requires familiar support for consultations which may cause her distress.
High	Essential support assistants AND / OR a single birth partner in active labour	Women to attend appointments alone. However essential support assistants able to attend to provide specified support. One nominated adult may accompany the woman attending where she requires familiar support for consultations which may cause her distress.	Women to attend appointments alone. However essential support assistants able to attend to provide specified support. One nominated adult may accompany the woman attending where she requires familiar support for consultations which may cause her distress	Specified scans: One nominated adult to accompany the woman to the appointments specified below where social distancing can be achieved. All other scans: As very high risk level
Medium	Essential support assistants AND /	Essential support assistants AND /	Essential support	Specified scans: One

	OR a single birth partner in all stages of labour if national guidance on social distancing can be achieved in the local setting	OR up to one designated /nominated visitor if national guidance on social distancing can be achieved in the local setting	assistants AND / OR up to one designated /nominated visitor if national guidance on social distancing can be achieved in the local setting.	nominated adult to accompany the woman to the appointments specified below* where social distancing can be achieved All other scans: As very high risk level
Low	Phased reintroduction of usual birth policies, if different to medium risk level	Phased reintroduction of usual visiting policies, if different to medium risk level.	Phased reintroduction of usual visiting policies, if different from medium risk level	Phased reintroduction of usual visiting policies, if different from medium risk level.

409. As noted in the above table the guidance was clear that consideration should be given to the needs of women who require additional support to access maternity services and for whom reasonable adjustments may be required. This may be in the following situations, which were by no means exhaustive:

    a. Women with a mental health issue, a learning disability or autism, where not being accompanied would cause them to be distressed.

b. Women with cognitive impairment who may be unable to recall health advice provided.

c. Where the treatment/procedure is likely to cause the woman distress and the partner/nominated other can provide support.

d. Where a woman has specific communication needs and may require support to understand information

410. It was also noted that women with support needs such as those listed above may require an essential support assistant to accompany them to appointments and when in a hospital setting. These are individuals required by women with specific additional support needs, e.g. a support worker or interpreter. Essential support assistants were not to be classed as visitors in the traditional sense. In some circumstances, where a woman usually received care and support from a family member or partner, they were able to nominate this person as their essential support assistant.

Gareth Howells

411. On 18 June 2021, the Hospital Visiting Guidance was updated once more, as exhibited in **M3CNOW01/207- INQ000082115**. As in Jean White's case, the Nursing Officer for Maternity and Early Years contributed to the maternity sections of this Guidance, which I signed off as the Interim Chief Nursing Officer.

412. The updated guidance introduced regular Lateral Flow Device testing to help facilitate partner / parent support during pregnancy, birth and the postnatal period, subject to local determination, and following a local risk assessment and the ability to maintain social distancing. The 'Annex 2' guidance remained the same as in the table reproduced in Jean White's section above.

Sue Tranka

413. The Hospital Visiting Guidance outlined above remained in place until updated on the 9 May 2022, as exhibited in **M3CNOW01/208-INQ000082810**. The Nursing

Officer for Maternity Services contributed to the to the maternity sections of this Guidance, which I signed off as the Chief Nursing Officer. The new guidance was designed to support local services when planning and implementing their visiting arrangements for maternity and neonatal services. It was co-produced, with discussion and consultation across health boards, Maternity Services Liaison Committees and service users, coordinated by the Wales Maternity and Neonatal Network and was in line with current Public Health Wales and Welsh Government policy.

414. The main change was set out in Annex 2, which was revised to ensure local visiting guidance met key principles. This included that a nominated partner supporting a woman during hospital visits and parents/primary care givers are considered partners in care, including in neonatal settings, not visitors. They would be categorised as essential visitors. The guidance included minimum standards to ensure consistency of approach across Wales, providing equity of experience. The visiting guidance also details the individual responsibilities of service users and health boards in maintaining a safe environment and to work together collaboratively.

415. The minimum standards for visiting guidance for maternity and neonatal units was set out in Annex 2 as:

Care setting	**Minimum standard**	**Managing an active outbreak**
Early pregnancy units	Nominated person to attend all early pregnancy appointments including scanning and consultations	Consideration to maintain partner presence
Antenatal care	Nominated partner to attend all antenatal appointments and scans, subject to risk assessment of physical environment.	Maintain access to dating and anomaly scan appointments

	Plan for person centred access as soon as the risk allows	
Labour and birth	Nominated partner present for labour assessment. Nominated partner present for active labour and birth. Local assessment of ability to have nominated partner throughout induction of labour. Plan for person centred access as soon as the risk allows	Birth partner present for active labour
Inpatient wards	Nominated partner present for specified times, maintaining an appointment system whilst social distancing is required. Plan for person centred access as soon as the risk allows	Visiting according to local risk assessment
Neonatal care	Both parents have unrestricted access as primary care givers. Any additional visitors to be determined by risk assessment and condition of the baby. Parents to remove face masks when baby is skin to skin, where possible.	Both parents subject to local risk assessments and physical distancing

416. The national hospital visiting guidance was removed on 11 November 2022.

The translation and interpretation of guidance for maternity services during the relevant period

Jean White, Gareth Howells and Sue Tranka

417. We have been asked to describe the CNO's involvement, if any, in the translation and interpretation of guidance for maternity services during the relevant period. We had no such role in translating or interpreting guidance relevant to maternity services.

418. Guidance from bodies including the Royal College of Midwifery, the Royal College of Obstetricians & Gynaecologists, the British Association of Perinatal Medicine, the Royal College of Paediatrics and Child Health, and the National Institute for Health and Care Excellence (NICE) was followed and formed the core guidelines used by health boards and communicated to women and families. In terms of vaccinations, again the guidance of the JCVI was adhered to and not translated by the CNO. The Chief Midwifery Officer, formerly the Midwifery Adviser and Policy Head for Maternity Services, worked closely with health boards to ensure any changes to policy were communicated and over time, allowed for flexibility to account for local circumstances and risk assessment.

Antenatal and postnatal contacts

Jean White, Gareth Howells and Sue Tranka

419. On the 30 March 2020 the Royal College of Obstetricians and Gynaecologists issued 'Guidance for antenatal and postnatal services in the evolving coronavirus (COVID-19) pandemic'. This guidance provided that women should continue to receive a minimum of eight antenatal consultations and out of these, at least six contacts should be in-person. In relation to postnatal contacts, the minimum recommended number of postnatal contacts was three, at day 1, day 5 and day 10.

420. These guidelines aimed to ensure that pregnant individuals receive essential care during the evolving coronavirus pandemic while considering social distancing

measures. This guidance, and subsequent updated iterations, was supported by the CNO for Wales during the relevant period.

421. Implementation of this guidance by health boards in Wales was not formally monitored by the Chief Nursing Officer however maternity services as a whole were monitored via the regular meeting updates and No Suprises process as outlined in this statement already.

422. In terms of any concerns about the implementation of the guidance, none of the CNOs in post during the relevant period recall any specific difficulties or instances of non-compliance.

423. In terms of whether the use of technology was an adequate and appropriate alternative, in the unique circumstances of the pandemic, all three Chief Nursing Officers agree it was.

Concerns or issues relating to maternity services raised during the pandemic

Jean White, Gareth Howells and Sue Tranka

424. As noted already in this statement, the Chief Nursing Officer and the Nursing Directorate were in regular contact with the NHS during the pandemic. There were weekly meetings between the leads in midwifery, health visiting and special schools and that any issues or outcomes from these meetings would feed into work being undertaken on essential services and vulnerable families. In relation to maternity care the main message was that women should continue to access routine appointments and discuss any concerns with their midwives.

425. It was a difficult time for all expecting mothers and families and it was understandable that the Nursing Directorate received a number of concerns or questions about maternity services during this period.

Access for partners, visitors and other supporters of pregnant women

Jean White

426. In respect of access for partners, visitors and other supporters of pregnant women, correspondence was received by the Chief Nursing Officer's team directly and on behalf of the Minister which were replied to.

427. By way of example, on 8 April 2020 the Nursing Directorate received concerns from Rhian Davies, Chief Executive of Disability Wales, noting that one of their pregnant members was concerned about her partner being able to accompany her into hospital to meet her specific support needs. The Nursing Officer for Maternity Services replied to this noting that midwifery support and individualised care remained vital to every birth experience, and her support needs should be discussed with her midwifery team and they will work to ensure appropriate support is put in place. Despite Covid-19, the guidance was that midwives would be able to make reasonable adjustments, when the well-being of the patient requires it, whilst taking into account the risks for all involved. This email exchange is exhibited in **M3CNOW01/209-INQ000412494.**

428. A number of concerns were also received from Members of the Senedd or the public via social media or email, particularly over the Summer of 2020 when there was some easing of restrictions. These were typically sent directly to the Minister for Health and Social Services, which at start of the pandemic was Vaughan Gething. Correspondence was drafted by the Nursing Directorate for the Minister to issue and, as exhibited in **M3CNOW01/210- INQ000412560** and **M3CNOW01/211-INQ000412562.** The issues raised and the responses were broadly similar, confirming that:

    a. Guidance to health boards was issued on 20 July and was implemented across Wales. If the requirements of infection prevention and control can be met locally, in line with national guidance, when a woman is attending

the hospital for the following reasons they may be accompanied by their partner or nominated person (preferably from the same household):

i. early pregnancy assessment unit scan (EPAU)

ii. early pregnancy dating scan (11+2 to 14+1 weeks)

iii. fetal anomaly scan (18+0 to 20+6 weeks)

iv. attendance at Fetal Medicine Department (to note that attendance at fetal growth scans are not currently included and will be attended by the woman only).

b. Partners can also attend the birth of the baby from the time a woman is in active labour and for some time after the birth. In the case of a planned Caesarian Section this is a local decision based on a Health Board's own risk assessments and will have due regard to the safety of the woman and baby and the doctors, midwives and fellow health professionals who are responsible for her care. At most other times when a woman is in the maternity unit, she will be sharing spaces and facilities with other women and their babies.

c. All women who need to remain in hospital following the birth of their baby will continue to receive individual support from the midwives and other health care professionals to care for their baby and maintain their own well-being.

d. Health boards will also take into account any individual circumstance a woman may have, for example, mental health needs, a learning disability or cognitive impairment where support is needed in order to process information. Whilst we cannot comment on individual cases, midwives / obstetricians will be able to make reasonable adjustments, when the well-being of a woman and baby require it, whilst taking into account the risks for all involved. We would expect the clinical team to work with any woman

with additional needs or concerns to explore all the options, including diverging from the visitor guidance if necessary, and agree together how best to provide support at this important time. If an individual is feeling anxious about anything, they should speak to their midwife about their concerns and feelings, as they are there to provide support and guidance. They will also be able to support them after they have returned home and discuss any concerns they have during the handover to their health visitor.

429. Similarly, a concern about partner access during labour was raised on Radio Wales Breakfast Show when a viewer asked:

"Please ask the FM what he plans to do about pregnant women facing pregnancy growth scans on their own, fertility treatment and parts of birth? The virus isn't going away so can he look at making this part of service Covid secure so both parents can be there and pregnancy women get the support of their partner that so many need. Midwives are amazing but it's not the same support."

430. The Nursing Officer for Maternity Services provided a response to the Communications Team which was cleared by me, as exhibited in **M3CNOW01/212-INQ000412526**. The response noted:

a. "A Welsh Government spokesperson said: "The safety and wellbeing of mothers and babies, as well as the staff who support them, is at the heart of the maternity visiting guidance at this time. A partner can be present when a woman is in active labour which minimises risks of cross infection due to her being within an individual room.

b. "The revised guidance published on 20 July extended visiting to specific ultrasound scan appointments.

c. "Health boards will take individual circumstances into account to enable a partner or a nominated person to be present when a woman is using maternity services if she has mental health needs, a learning disability or a cognitive impairment or needs extra support to process information."

431. A report published by Community Health Councils in Wales, which serves as the independent voice of people who use NHS services, reviewed maternity care through the first part of the pandemic. The report, which is exhibited in **M3CNOW01/213-INQ000412570,** shows that some families were affected by issues such as visiting restrictions that needed to put in place during this period although many families also reported positive experience and support provided. This report captured views but did not provide any analysis or recommendations. It was however useful in highlighting that whilst people told the Community Health Councils, they understood things had to change, they also heard how this was affecting them. They heard that for some people this was not only affecting their experience of antenatal care and labour, but also on their on-going care and support after birth. This was important feedback for the service.

Concerns relating to a reluctance amongst pregnant women to attend healthcare settings due to fear of contracting Covid-19 or otherwise

Jean White

432. As noted above, concerns and issues were brought to our Nurse Directors weekly calls. For example, on 31 March 2020 I was aware that there had been a rise in home births as mothers were scared to go into hospital to birth due to Covid-19. We agreed to issue public messaging to dissuade mothers from unplanned home births and we worked with the Welsh Ambulance Service (WAST) on this, I exhibit a note of the minutes as **M3CNOW01/69** - **INQ000412476**.
433. Home and free birth messaging was clear that postnatal care was still in place and the Nursing Directorate continued to work with health boards to look at ways in which the service could instill confidence in new mothers to access support. For example, the same midwife or health visitor undertaking 10 days weight checks to avoid concern about risk of infection from another individual but to ensure services picked up any babies who were failing to thrive.
434. Alongside actions by the Nursing Directorate during this time there was also a national media campaign from around May 2020 across those service areas

designated as essential services. An assessment of the adverting campaign was undertaken and exhibited in **M3CNOW01/215-INQ000399072,** noting that the primary objective of the campaign was to raise awareness and included social media, print media, radio and visual displays, recognised that while much of the health and care workforce is focusing on dealing with the Covid-19 pandemic, health and care staff across the country are still providing essential services for the people of Wales. The general messaging was: "If it's urgent, don't wait, don't leave it too late. We are here for you to help you get the care you need". Specifically for maternity services the message was that the service was open for business and it was really important that women continue to attend scheduled routine care when they are well. Messaging noted:

> "Maternity care is essential, and has been developed over many years to reduce complications in mothers and babies. There is a potential risk of harm to you and your baby if you don't attend your appointments, even in the context of coronavirus. It's even more important in these uncertain times that women during pregnancy and following childbirth access the support and care they and their families need. If you are pregnant, it is important that you still attend your antenatal appointments and continue to seek advice from your midwife or maternity team. If you are worried about your health or the health of your unborn baby, please contact your midwife or maternity team."

Gareth Howells

435. I do not recall any specific concerns raised during my time as Interim Chief Nursing Officer but we were aware of this issue and the Essential Services Subgroup which was part of Health and Social Services Planning and Response Group continued to ensure that the key messages outlined above were maintained.

Sue Tranka

436. As noted by Jean and Gareth above, ensuring women felt comfortable and able to access midwifery support continued to be a pressing issue after I took up the post of Chief Nursing Officer.

437. Concerns were raised at the Health and Social Services Group's Quality and Delivery Board (QDB) on the 16 September 2021, as referenced in exhibit **M3CNOW01/216-INQ000412564**. This noted that a number of Maternity services in Wales were under operational pressure and there were also reports of some mothers choosing to "freebirth" (birthing on their own without midwifery assistance) indicating that they are concerned to attend hospitals due to the risk of contracting Covid-19. This led to an increase in maternity related incidents and sadly one nationality reportable maternal death.

Concerns about neonatal services

Jean White

438. I do not recall any specific concerns about neonatal services, however an issue was raised regarding the importance of 6 weekly checks for babies which detect and prevent conditions which could lead to blindness, heart disease, hip dysplasia, cancer and infertility. The Nursing Directorate engaged in internal discussions about how to support delivery of immunisations and 6 week checks by training band 4 nursery nurses and physician associates to support GPs. The email chain is exhibited in **M3CNOW01/217-INQ000412466**. The training of nursery nurses was not taken forward due to workforce pressures in neonatal areas. I am not aware if any action was taken in relation to physician associates.

Gareth Howells

439. I do not recall any specific concerns about neonatal services during my time as Interim Chief Nursing Officer.

Sue Tranka

440. As Chief Nursing Officer for Wales, I do not recall any specific concerns about neonatal services from August 2021 to the end of the relevant period.

Other concerns related to maternity services

Jean White, Gareth Howells and Sue Tranka

441. All three Chief Nursing Officers for the relevant period, in consultation with the Nursing Officer for Maternity Services and current Chief Midwifery Officer for Wales have considered and do not recall any specific concerns or issues related to:

a. the requirement for women to wear face masks during labour;

b. access to pain relief, such as water births;

c. access to elective caesarean sections;

d. access to interpreters or translators.

Inequality issues relating to maternity services

Jean White, Gareth Howells and Sue Tranka

442. All three Chief Nursing Officers for the relevant period, in consultation with the Nursing Officer for Maternity Services and current Chief Midwifery Officer for Wales, have considered and do not recall any specific concerns or issues related to inequalities in maternity services.

443. The First Minister established the Covid ethnic disparity group chaired by Emmanuel Ogbonna. Issues in relation to uptake of vaccine for women with ethnic descent were highlighted as requiring positive action within health boards by multiple mechanisms to deliver vaccine.

444. The Report on the impact of Covid-19 on disabled people in Wales, as exhibited in **M3CNOW01/218- INQ000350302**, was commissioned by Jane Hutt, Minister for

Social Justice, from the from the Disability Equality Forum. The Minister wanted to establish an evidence-based enquiry into disabled people's experiences during the pandemic. A Steering Group was convened to oversee the production of the Report made up of disabled people representing Disabled People's Organisations (DPOs) and disability charities, supported by the Welsh Government who provided administrative support as well as supplementary research expertise and data analysis. The coordinator of the report was Dr Debbie Foster who is Professor of Employment Relations and Diversity at Cardiff University's Business School.

445. This report was finalised in March 2021 and noted maternity provision had been uneven across health boards in Wales during the pandemic. It noted increased levels of stress, anxiety, mental health distress and baby loss among women. Additional barriers have been experienced by disabled women, including the accessibility of Covid-19 compliant maternity environments. Where there has been a genuine need to be accompanied by an advocate or partner, disabled women have had problems conveying this and other adjustments in respect of revised processes and practices. After-birth care, including visits from health visitors to the home have been largely cancelled and conducted over the phone, excluding many mothers who are Deaf or have hearing loss. Evidence also suggested perinatal mental health issues were less likely to be identified in the absence of face-to-face appointments. It will be necessary to assess the long-term effects on future generations of inadequate and inaccessible maternity services.

446. The report recommended an assessment of the long-term effects on future generations of inadequate and inaccessible maternity services during the pandemic. Accessible and specialist services closer to home require investment. It also recommended that women be allowed to self-register their requirements and that requests for reasonable adjustments are properly formalised to allow for proper consideration of whether a partner / advocate is needed at appointments.

447. In response to the recommendations the Nursing Directorate confirmed that senior leaders in maternity services had discussed the lessons learnt in the pandemic and

these were being used to review the actions which underpin the delivery of Welsh Government's Maternity Vision was published in July 2019. In addition, a survey of women who have had a baby in the last year is being undertaken by the Consultant Midwife group to ensure their experience of accessing maternity services is understood and the resulting learning can influence future direction of the Vision. Work continues in respect of this.

Other matters within the scope of Module 3

Jean White, Gareth Howells and Sue Tranka

448. We have been asked to describe our involvement, if any, in relation to a number of different areas within the scope of Module 3 of the Inquiry:

The establishment and/or operation of temporary hospitals

Jean White, Gareth Howells and Sue Tranka

449. This area is not within the responsibility of the Chief Nursing Officer but fell within the Director General Health and Social Services ("DG HSS") remit and was led by that office and wider team.

Jean White

450. Field hospitals in Wales were open and utilised consistently from October 2020, and I have provided an overview of the staffing model adopted for field hospitals in Wales in paragraph 85 of this statement.

451. As a member of the Executive Director Team, I was aware of and had updates regarding the establishment of temporary hospitals, referred to as "field hospitals" in Wales. For example, at an Executive Director Team meeting on 25 March 2020 we discussed the development of field hospitals with support from the Ministry of Defence. The minutes of this meeting were previously exhibited at **M3CNOW01/017–INQ000353490**. Aside from my role as a member of the Executive Director Team, I did not have any involvement in the establishment of field hospitals.

The use of private hospitals

Jean White, Gareth Howells and Sue Tranka

452. This area is not within the responsibility of the Chief Nursing Officer but fell within the Director General Health and Social Services ("DG HSS") remit and was led by that office. As such none of the Chief Nursing Officers for Wales during the relevant period had any involvement in decisions regarding the use of private hospitals or the allocation of nursing staff within the healthcare system, including private hospitals and temporary hospitals.

The allocation of nursing staff within the healthcare system, including within private facilities and temporary hospitals;

Jean White, Gareth Howells and Sue Tranka

453. We had no involvement in the allocation of nursing staff within the healthcare system, whether within private facilities temporary hospitals or elsewhere.

The use of technology

Jean White, Gareth Howells and Sue Tranka

454. The Heath and Social Services Technology and Innovation team, which is part of the Digital Transformation and Chief Digital Officer's Directorate leads on the use of technology for the Health and Social Services Group within the Welsh Government.

Jean White

455. Maternity care was classified as an essential service and therefore all pregnancy and postnatal care remained in place maintaining strict infection control procedures. Where clinically appropriate however and following risk assessment some visits were able to take place using virtual technology.

456. At the end of May 2020, my team issued revised guidance to health visiting services in Wales, based on the Institute of Health Visiting's 'First Birth Visit' guidance as exhibited in **M3CNOW01/219–INQ000299943**. This new guidance promoted the use of virtual technology and built on the previously issued Healthy Child Wales Programme guidance and Public Health Wales' document 'Parenting Give it Time'. The guidance noted that parental choice and consent to the health visiting service offer is an important consideration when we are being told that families understandably do not want home visits and that the presumption should be that contacts will be virtual – using video-enabled technology or, failing that, telephone contacts. The guidance echoed what was set out in the Institute of Health Visiting's guidance, exhibited in **M3CNOW01/220–INQ000300107**. The Institute's guidance set out that respecting choice to engage in virtual contacts was important during times of crisis as everyone's anxiety levels were increased. Equally important was the need to safeguard the whole family and intervene as required if a risk was identified as per local guidance.

457. Face to face antenatal preparation classes were paused during the pandemic. To ensure continued availability Public Health Wales have purchased a platform for virtual online classes which was available free to all women.

458. A request was made to the Minister for Health and Social Services on 1 February 2021 to approve £1,310,549 funding to provide health visitors, school nurses and community children's nurses with IT devices to support and enhance the provision of services during the pandemic. I produce here the Ministerial Advice which was submitted by the Health and Social Services Technology, Digital & Transformation Directorate, as exhibit **M3CNOW01/221–INQ000235859**. I did not prepare this advice but I was a copy recipient and noted that some health board community services did not have the equipment needed to run virtual appointment applications (which in Wales were part of 'Attend Anywhere' applications). Additionally, during a recent roll out of IT requirements the health visiting, school nursing service and community children's nurses were not considered. Providing Health Visitors (including Flying Start), School Nurses and Community children's nurses with fit for

purpose devices would provide long-term benefits, over and above the ability to hold video consultations. The Minister approved this funding, as exhibit **M3CNOW01/222–INQ000299768.**

Gareth Howells

459. As Interim Chief Nursing Officer, I did not have any involvement in the increased use of technology in healthcare settings, such as remote patient consultations, when I was in post during the relevant period.

Sue Tranka

460. As Chief Nursing Officer, I did not have any involvement in the increased use of technology in healthcare settings, such as remote patient consultations, when I was in post during the relevant period.

Shielding policy for clinically vulnerable and clinically extremely vulnerable people

Jean White, Gareth Howells and Sue Tranka

461. Shielding policy for clinically vulnerable and clinically extremely vulnerable people in Wales was led by the Chief Medical Officer and the Population Health Directorate within the Welsh Government.

Jean White

462. I did not have significant involvement in the policy for clinically vulnerable and clinically extremely vulnerable people in Wales but I and my team were copied into the discussions that took place between the UK Chief Medical Officers in March 2020 and were invited to comment upon the criteria for women and children from a maternity and pediatrics view. Aside from the initial engagement I did not have any involvement or role in the policy that followed.

Gareth Howells

463. As Interim Chief Nursing Officer, I did not have any involvement in the shielding policy for clinically vulnerable and clinically extremely vulnerable people in Wales.

Sue Tranka

464. As Chief Nursing Officer, I did not have any involvement in the shielding policy for clinically vulnerable and clinically extremely vulnerable people in Wales during the relevant period.

Suspending non-urgent elective surgery and diagnostic screening programs

Jean White, Gareth Howells and Sue Tranka

465. This would be a matter for the NHS in Wales to make decisions on at a local level. Support would have been provided by the DG HSS and Chief Executive of NHS Wales in relation to this. As such none of the Chief Nursing Officers for Wales during the relevant period had any involvement in decisions to suspend non-urgent elective surgery and diagnostic screening programs.

Maintaining healthcare and treatment for patients with non-Covid-19 conditions, such as the establishment of risk-based clinical pathways, in particular ischaemic heart disease, colorectal cancer, patients requiring a hip replacement; inpatient Children and Adolescent Mental Health Services ("CAMHS"); and palliative or 'end of life' care for patients with Covid-19

Jean White, Gareth Howells and Sue Tranka

466. Local Health Boards and Trusts are responsible for planning and delivery of cardiac services in line with clinical best practice, professional standards and performance expectations. NHS waiting times and performance data were considered by Health Boards at their Integrated Quality, Delivery and Performance meetings and reported to the NHS Wales Execuitve Board meetings. Action required as a result of the performance data would be determined by the relevant Local Health

Board and, should external decision and input be required, by the Chief Executive NHS Wales. From 2022, a regular update on waiting times and performance information was shared at Executive Director Team meetings.

Jean White

467. I had no involvement in the operational decisions made by the Health Boards in respect to day-to-day delivery of care. I was a member of the NHS Planning and Response Cell, led by Samia Saeed-Edmonds, where the Chief Operational Officers from the NHS organisations met regularly (initially weekly) to discuss how they were reconfiguring services. Local Health Boards and Trusts are also supported and enabled to deliver improved services for people through clinical networks, for example, in respect of heart conditions via the Wales Cardiac Network. This is a clinical network. There was also an Essential Services Cell focused specifically on keeping non-Covid care available, including for cancer care. I did not attend this Cell on a regular basis but members of my team did. These service-facing Cells helped keep Welsh Government informed and was an opportunity for the Chief Operating Officers and Service leads to share experiences and approaches.

468. In respect of CAMH services, I note that the Nurse Director meeting minutes dated 20 November 2020, which I have previously exhibited in **M3CNOW01/102-INQ000412577**, include a reference to 'pressure on CAMHS Tier 4 services'. However, I have no specific recollection of this, and it is not an issue on which I as CNO would have taken any direct action. Further detail on CAMHS services during the pandemic and the Welsh Government response is set out in the Welsh Government's M3-WGO-02 witness statement.

Gareth Howells

469. I had no involvement in the development of these pathways, which were owned by each individual Health Board.

Sue Tranka

470. As we came out of the winter and the Covid-19 situation stablised, I provided advice along with Professor Chris Jones, Deputy Chief Medical Officer, dated 20 May 2022, relating to 'De-escalation of COVID-19 measures in NHS Wales to enable transformation and modernisation of planned and elective care and to reduce waiting times', exhibited earlier in the statement in **M3CNO01/078-INQ000353329.** In that letter we set out the de-escalation of the Covid-19 measures which included returning to the National Infection Prevention and Control Manual as the primary source of general IPC guidance and principles and reducing the isolation period for Covid-19 positive patients where possible.

471. The advice was provided to the NHS in Wales, as plans to remove the last elements of the emergency legislation on the 30 May 2022 were imminent and the Welsh government had started to integrate Covid-19 specific approaches, including test, trace, protect into our public health response for communicable diseases, and in particular respiratory infections. This has enabled us to use the infrastructure and capacity we have established for the Covid-19 response to support other programmes.

472. They specifically refer to:

    a. Social distancing - analysis of the evidence and data meant we were able to provide advice to the service that there is no longer a requirement for social distancing: Other than in clinical areas where COVID-19 / Respiratory cases are being managed or in "high risk settings for ongoing transmission of COVID-19" where the risks cannot be mitigated by applying the hierarchy of controls, there is no requirement for social distancing or segregation of asymptomatic patients. Physical distancing can return to pre-pandemic arrangements, but organisations must ensure that they maintain compliance with all relevant Health Technical Memoranda and Health Building Notes.

b. Use of face masks for staff and face masks or coverings for all patients and visitors - in areas that are dealing with known or suspected cases of SARS-CoV-2 and other respiratory infections, the use of face masks for staff and face masks or coverings for all patients and visitors should be continued in compliance with infection prevention and control guidance. Once the current legal requirement is lifted, it remains the responsibility of the Local Health Board to ensure that staff and visitors comply with infection prevention and control guidance for health and care settings - and continue to be advised and supported to use masks or face coverings in public areas of hospitals.

Long Covid

Jean White

473. During my tenure as CNO, the CNO's office was not responsible for the policy in relation to long Covid and I did not personally have any direct involvement in the development of such policy. However, whilst not responsible for the policy in relation to long Covid, NR and Name Redacted of the Nursing Directorate were attending members of the Rehabilitation Task & Finish Group and the Long Covid Sub-Group, respectively. I was aware that the policy approach adopted by the Welsh Government in relation to long Covid is an integrated rehabilitation service model enabling people to access support through existing primary and community care structures and, where necessary, from inpatient rehabilitation services. I exhibit a copy of a statement issued by the Minister for Health and Social Services, Vaughan Gething, dated 22 October at exhibit **M3CNO01/224- INQ000412528** which sets out the Welsh Government's policy approach to rehabilitation services for people recovering from long Covid in further detail. As referred to in the statement, the approach adopted by the Welsh Government was supported by a National Rehabilitation Framework which was first published by the Welsh Government on 29 May 2020 and I exhibit at **M3CNO01/225-INQ000369596**. The framework was designed to support the rehabilitation and recovery of people who have been affected

by COVID-19, including those who have been hospitalised or who have experienced long-term symptoms. It provided guidance on a range of issues, including the assessment of rehabilitation needs, the development of individualised care plans, and the delivery of rehabilitation services in a safe and effective manner. The framework also emphasises the importance of a collaborative and multidisciplinary approach to rehabilitation, involving a range of healthcare professionals, including doctors, nurses, physiotherapists, occupational therapists, and psychologists. The framework was intended to support the ongoing recovery of people affected by Covid-19 and to help them regain their health and wellbeing.

474. I recall querying with NR the Chief Allied Health Professions Advisor, whose directorate had responsibility for long Covid at that time, why the Welsh Government had not established any long Covid centres as NHS England had done. I was advised that the reason that Welsh Government had not pursued this was because there was concern that such clinics would duplicate the existing rehabilitation service structures that were already available via primary and community care and would not assist those people who had not suffered with Covid-19 but had nevertheless been impacted. It was considered that the model adopted by the Welsh Government maximised our resources most effectively for people including those with more complex rehabilitation needs, irrespective of whether their needs arose from Covid-19.

475. Any nursing staff and midwifery staff suffering from long Covid would have been able to access rehabilitation services in their respective local areas in the same way as other people in Wales would have done so.

476. During the latter part of my tenure in February 2021, I am aware that the Welsh Government published the "All Wales Community Pathway for Long Covid" which provides clinical guidance on the management and treatment of long Covid, including in what circumstances a referral to more specialised services may be appropriate. I exhibit a copy of the most recent version of the All Wales Community Pathway for Long Covid at **M3CNO01/226-INQ000412547**. This provided a flow diagram of the

pathway. For the purposes of ensuring consistency in the implementation of the All Wales Community Pathway for Long Covid, the Welsh Government commissioned the Institute of Clinical Science and Technology to produce a digital "guideline" called the "All Wales Guidelines for the Management of Long Covid" which provides health and care professions in primary and community care settings across Wales with a holistic and integrated suite of resources and training, enabling them to help and advise people recovering from long Covid. Both the All Wales Community Pathway for Long COVID and the All Wales Guidelines for the Management of Long Covid promote the use of the NHS Wales Covid Recovery App which was launched on 20 January 2021.

477. I exhibit a press release dated 20 January 2021 outlining the launch of the NHS Wales Covid Recovery App at **M3CNOW01/227-INQ000469194**. The NHS Wales Covid Recovery App was commissioned by the NHS to support people experiencing the longer-term effects of coronavirus such as those suffering with long Covid, including enabling them to track their symptoms and progress and providing advice on managing their condition at home with support. Again, nursing and midwifery staff who were themselves suffering from long Covid would have benefited from these services.

478. As regards support for nursing and midwifery staff within the NHS in Wales suffering with long Covid, other than the support set out above, I am aware that Dr Andrew Goodall circulated a Welsh Health Circular WHC/2020/019 on 30 October 2020 entitled "Expectations for NHS Health Boards and Trusts to ensure the health and wellbeing of the workforce during the Covid-19 pandemic". I exhibit a copy of the Welsh Health Circular at **M3CNOW01/228–INQ000355926**[5]. The Welsh Health Circular sets out the expectation for all NHS Health Boards and Trusts in Wales to

---

[5] *This exhibit has been provided by another material provider to the UK Covid-19 Inquiry and is a duplicate of a document held by the Welsh Government and disclosed to the UK Public Inquiry [INQ000412592]*

support the health and wellbeing of their workforce by facilitating access to the coherent and coordinated package of support which has been made available and includes reference to a Covid-19 webpage developed by Health Education and Improvement Wales (HEIW) which contains links and signposting to a range of resources including resources for long Covid. The Welsh Health Circular also sets out that Dr Andrew Goodall expected NHS organisations to maintain up to date local webpages on staff health and wellbeing, and to promote awareness of and encourage access to the national and local resources available amongst staff and managers.

479. I am also aware of changes that were made to the terms and conditions of service NHS handbook which meant that, prior to 1 December 2020, normal sickness provisions were paused for absences arising out of the Covid-19 infection, which meant that affected staff were paid full pay without that absence having any impact on their sick pay entitlement. This changed from 1 December 2020 so that where any continuous/long-term Covid-19 related sickness absence started after that date then entitlement is for 12 months full pay from the date their absence commenced.

480. I am not aware of any issues or concerns regarding the prevalence of long Covid amongst nursing and midwifery staff and/or support available to those suffering from long Covid that were brought to my attention during my tenure as CNO.

Gareth Howells

481. My recollection is that the Deputy CMO led on long Covid during my tenure as interim CNO and my role was to maintain the areas of focus outlined by Jean White in the paragraphs above. I do not recall any concerns being raised in relation to long Covid amongst nursing and midwifery staff during my tenure.

Sue Tranka

482. Since 25 April 2022, the Nursing Directorate, is now known as the Quality and Nursing Directorate and includes long Covid within its remit. Accordingly, my directorate has held the policy responsibility for long Covid. However, I am aware

that, since June 2021, the services for long Covid have been provided through the "Adferiad (Recovery Programme)", for which the Welsh Government allocated £5m to the seven Welsh local Health Boards for the period 2021/2022 to support the delivery of community level rehabilitation services with referral pathways to specialised secondary care services for those were need it. This was initially allocated on a non-recurrent basis but a further £5m was allocated for the period 2022/23 to continue the development of Adferiad funded services. This development was consistent with the broader strategic direction for the NHS under A Healthier Wales and the Strategic Programme for Primary Care, so would in effect also support a broader transformation. I exhibit a policy and strategy document for the Adferiad (Recovery) programme dated 15 June 2021 at **M3CNOW01/229-INQ000412566**. This document includes:

a. A description of how the £5m funding would be spent:

    i. Helping healthcare workers and Allied Health Professionals develop infrastructure to flexibly deliver services to help people recover from COVID-19, long COVID and those more widely impacted by the pandemic.

    ii. Providing high quality, evidence based training and digital resources to assist in diagnosing, investigating and treating long COVID and supporting people in their treatment and rehabilitation.

    iii. Investing in digital tools which will provide data about service demand and capacity modelling and ensure the NHS helps people make the right treatment decisions for their care and treatment

b. Confirmation that all health boards had developed multidisciplinary recovery services that GPs and health professionals were able to refer their patients into, after screening for more serious symptoms. All services also had a comprehensive assessment tool to ensure patients are treated holistically and individually.

c. Advice and resources in respect of mental health and wellbeing for people with long Covid.

d. Details of the support available for NHS employees:

i. The update to sickness absence from 1 December 2020 as described earlier in this statement

ii. Where an individual exhausts their sick pay entitlement, employers have the discretion to extend the period of sick pay on full or half pay where there is the expectation of return to work in the short term and an extension would materially support a return and/or assist recovery

iii. That where an individual has returned to work and is still in the process of rehabilitation, any subsequent episodes of sickness absence will be paid as per an individual's normal contractual sickness entitlements.

483. In March 2023, the Welsh Government increased the funding for the Adferiad (Recovery) Programme to £8.3m on a recurrent basis for 2023/24 onwards. This increase in funding is to ensure continued support for people with long Covid, and also to allow people suffering from other long-term conditions which have similar rehabilitation and recovery needs to those with long Covid such as, such as ME and Chronic Fatigue Syndrome, to also access Afdferiad funded services. I exhibit at at **M3CNOW01/230-INQ000412567** a written statement issued by the Minister for Health and Social Services, Eluned Morgan MS, on 14 March 2023 providing an update on the Adferiad (Recovery) Programme and the increase in funding as described above. Nursing and midwifery staff suffering with long Covid would have access to Adeferiad services in the same way as other people in Wales suffering from long Covid.

484. In terms of any specific support for nursing and midwifery staff suffering with long Covid, the wellbeing of the workforce has remained a constant concern throughout my time as CNO. I recall that I was contacted by Dr Alison Twycross, who is an academic with a research interest in long Covid, raising concerns about the lack of adequate provision for nurses and midwives suffering from long Covid in Wales. I asked Name Redacted a Nursing Officer, to make enquiries on the current provision and I exhibit a chain of email correspondence at exhibit at **M3CNOW01/231-INQ000412555**, seeking clarity on resources available to support the workforce with long Covid. Such resources include the changes made to the sick pay provisions in the NHS standard terms and conditions of employment; resources from HEIW on long Covid and the NHS Wales Recovery App.

485. I also recall being contacted by a nurse from one of the health boards raising concerns about inflexible HR policy to support long term sickness. I raised this with the Workforce team at the Welsh Government and sought assurance via the then CEO at the health board in question that the application of their HR policy would be reviewed.

Processes in place for the nursing and midwifery professions to contribute feedback, learning and information to the CNO

Jean White

486. It was important that any lessons learned from NHS Wales were shared quickly to ensure good practice was promulgated across the system. To this end, the NHS Wales Delivery Unit established the Covid-19 Rapid Sharing of Early Learning platform (at the behest of the Nosocomial Transmission Group. A letter was sent to the Nurse Directors and executive medical directors advising them about this new platform on 6 August 2020, and I produce here this letter entitled "Sharing early learning related to in-hospital transmission of Covid-19" as exhibited at **M3CNOW01/154–INQ000300114.** This letter included guidance, action points and proposed processes relating to the use of the platform, including the nomination of

members of staff to share early learning through the platform, sharing early learning in a timely manner (usually within 24-72 hours of identification), as well as use of the information by NHS organisations following dissemination through the platform. This platform did not require any changes to the reporting or investigation of in-hospital transmission of Covid-19 infections under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ("RIDDOR"), or the Welsh Government's no surprises and serious incidents reporting arrangements. Additional background information on the development and implementation of the Covid-19 Rapid Sharing of Early Learning information sharing system is found in the document "SBAR - reporting rapid learning relating to Covid-19 0.5", as previously exhibited at **M3CNOW01/156–INQ000299502.** The document includes the desired aims of the system, the system pilot proposal, the proposed information sharing process flow, and a draft letter to inform and prepare the Medical Directors NHS Wales and Directors of Nursing NHS Wales for the system trial.

487. There were several opportunities for Welsh Government officials to receive feedback from professionals involved in delivery of care, namely though:

a. Regular Executive Nurse Director meetings held with CNO.

b. Work with the Nursing and Midwifery Council to change nursing and midwifery education standards – there were representatives from trade unions and professional associations as part of this work. Health Education and Improvement Wales, who assisted in delivering the changes in Wales, worked alongside **NR** Nursing Officer, and involved the NHS Wales organisations and Higher Education Institutions that are contracted to educate health professional staff.

c. The various professional heads of services groups that the members of the Nursing Directorate liaised with throughout the pandemic, eg heads of midwifery services, heads of health visiting and school nursing services, heads of mental health and learning disability services, heads of district nursing services, etc. The Nursing Officers all maintained the pre-existing professional network of contacts during the pandemic.

d. The Welsh Nursing and Midwifery Advisory Committee.

e. Professional associations and trade unions such as the Royal College of Nursing and the Royal College of Midwifery, which were able to contact me at any time should their members raise issues that needed addressing at government level.

f. The various cells established as part of the Welsh Governments response, such as the Nosocomial Transmission Group and the Primary Care Cell.

g. Public Health Wales officials, which included nurses, were involved in UK work to develop the IP&C guidance and had close relationships with officials in the other devolved administrations to share intelligence and good practice. They then supported Wales through the Nosocomial Transmission Group.

488. The network of service specific professional reference groups predated Covid-19 and their existence was extremely valuable throughout the pandemic. These reference groups reported to the Welsh Nursing and Midwifery Advisory Committee and Executive Nurse Director group. Conversations with the members of these various service specific groups along with the Executive Directors of Nursing enabled officials to have real time feedback on issues happening in the delivery of care and in turn enabled Welsh Government decisions/policy changes to be communicated to service leaders. Engagement of nurses and midwives on the Nosocomial Transmission Group was immensely useful as this is the workforce that has most contact with patients and usually leads on infection prevention work within organisations.

489. I have provided instances earlier in this statement of issues or concerns raised by, for example, Nursing Directors and how my Directorate was able to take this feedback on board and respond.

Gareth Howells

490. As CNO my office has continuous dialogue with and feedback from the nursing and midwifery professions via the regular Nursing Directors meetings and the Heads of Midwifery meetings led by NR as well as through the Nosocomial Transmission Group. I believe these worked well and allowed me to take account of the professions' views in all my actions as CNO.

Sue Tranka

491. The avenues for feedback into the CNO(W) directly or via the OCNO were well established and operating effectively when I joined the Welsh Government. There are several mechanisms in place which continue to function well currently. The Welsh Nursing and Midwifery Committee is a formal group that provides formal feedback from Heads of Service represented at the group, and will raise concerns with the Nursing officers, OCNO or myself for consideration and action if required.

492. The Heads of Midwifery Group retain their current function and the Chief Midwifery officer, Name Redacted is an invited member to this group, providing update, sharing information and receiving feedback for information or action as necessary.

493. The Health Board/Trust Nurse Directors meeting remains a key meeting for information sharing, raising concerns, emerging risks and requesting specific action by the CNO on any matters of concern.

494. In addition, I have regular monthly one-to-one meetings with all Health Board and Trust Directors of Nursing across the Welsh system, including the Special Health Authorities. Open, transparent and regular feedback is sought as it relates to individual Health Boards, policy specific areas, or the wider professional agenda.

495. I continue to operate an open-door policy, and as such any member of the nursing and midwifery community is able to access my office for support or to raise any concerns that they feel require the attention of the Welsh Government.

496. I have described here the key meetings, but this list is not exhaustive. These key touchpoints remained critical throughout the phase of the pandemic when I took up post, in order to support and test decision-making with the service leads. I felt that this worked particularly well and aided open and two-way communication.

497. Before I joined, the Welsh Government commissioned the NHS Delivery Unit to set up the Covid-19 Rapid Sharing of Early Learning (CoRSEL) system as a mechanism to allow the rapid sharing of early learning relating to in-hospital transmission of Covid-19 across Wales. This system worked alongside the established pre-Covid-19 reporting systems for serious incidents. The idea of this was to share learning from both specific events or incidents but also from good practice. The Delivery Unit shared the findings of an evaluation of CoRSEL and found that the principle of a shared learning platform across the NHS was welcome and well received. However, as it was a separate digital system to those normally used across the NHS, in practice it wasn't utilised to its maximum. I understand from the NHS Executive Nurse Director group that the process of producing and sharing rapid learning could have been more successful if learning was shared in a nationally consistent digital platform. The concept, however, was deemed to be a positive and a welcome mechanism. The learning from CoRSEL was formally submitted to the Nosocomial Group for to Local Health Boards via the representatives.

498. Learning points logged by the NHS are reviewed by an oversight group, led by the Delivery Unit, which includes membership from the Welsh Government, Public Health Wales and Improvement Cymru. Details are communicated to NHS organisations for further consideration as to whether any local changes are required. The oversight group reported into the Nosocomial Transmission Group.

499. In addition, representatives from Public Health Wales attend the UK IP&C Cell. This Group reviews new evidence on infection prevention and control from a wide range of sources and has updated the UK guidance on a number of occasions during the pandemic.

Statement of Truth

I believe that the facts stated in this witness statement, in those sections bearing my name, 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.

Jean White

Signed: Personal Data

Dated: 1 May 2024

Gareth Howells

Signed Personal Data

Dated: 2 May 2024

Sue Tranka

Signed: Personal Data

Dated: 2 May 2024