Witness Name: Alex McMahon
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Exhibits: AMM2
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UK COVID-19 INQUIRY MODULE 3

WITNESS STATEMENT BY THE CHIEF NURSING OFFICER

This statement is one of a suite provided for Module 3 of the UK Covid Inquiry and these should be considered collectively. In relation to the issues raised by the Rule 9 requests served on the Scottish Government, in connection with Module 3, I, Alexander McMahon, will say as follows:-

1. I am Professor Alexander McMahon, I have worked for the Scottish Government as Chief Nursing Officer since October 2021, initially on an interim basis before occupying the role in a substantive manner from 1 January 2022. I retired from this post on 26 April 2024.

2. I have prepared this statement with assistance from others by reference to records and material provided to me by the SG. I have received assistance from the SG Covid Inquiries Response Directorate and the Chief Nursing Officer Directorate (CNOD).

3. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.

4. Given the relatively short span of time in which I held the position of CNO, as noted in paragraph 8, there are several issues on which I do not have additional insight to add beyond the information provided in Fiona McQueen's personal statement to Module 3 (UKIDM3CNO051). Where relevant actions were taken by me or by CNOD in my time as CNO, including updates to guidance, testing programmes and lessons learned exercises, they are detailed below. I have also added my own personal reflections, where appropriate.

5. References to exhibits in this statement are in the form [AMM2/number - INQ000000].

Biography

6. I am a registered mental health and general nurse (qualified in 1986 and 1989 respectively), registered with the Nursing and Midwifery Council (NMC). Over the course of my career, I have worked within the NHS and the wider health system, including for the Royal College of Nursing (RCN) and SG and in the private sector (AstraZeneca, a global pharmaceutical company). I have a degree and postgraduate diploma in education and a Masters in policy studies in addition to my nursing qualifications. I also hold two honorary professorships with the University of Stirling and Queen Margaret University respectively.

7. Prior to October 2021, when I became CNO, I was the Executive Director of Nursing, Midwifery and Allied Health Professions for NHS Lothian, a post I had held since 2016.

Role of the CNO

8. Three individuals held the post of Chief Nursing Officer (CNO) for Scotland during the period 1 March 2020 and 28 June 2022 ("the relevant period"):
    - Fiona McQueen: November 2014 until February 2021 (interim from November 2014, then substantive from April 2015)
    - Professor Amanda Croft: February 2021 to August 2021
    - Professor Alex McMahon: January 2022 to April 2024 (interim from October 2021, then substantive from January 2022).

9. As CNO, I was responsible at a national level for all matters that relate to the professional leadership of nurses, midwives, Allied Health professionals (NMAHP) and Healthcare Scientists (HCS) across Scotland. Given the impact of the NMAHP/HCS profession on improving health and delivering world class safe and effective healthcare, it supports the achievement of the best health and care outcomes by providing leadership of the professions.

10. As CNO, I was supported by a Deputy Chief Nursing Officer (DCNO), Chief Midwifery Officer (CMidO), Chief Allied Health Professions Officer (CAHPO) and Chief Scientific Officer (CSO), all of whom report directly to the CNO. The CNO also has their own Chief Nursing Officer Directorate (CNOD), which comprises policy officials and clinical and educational professional advisers. Within this function of the Directorate, the CNO is supported by two civil servant Deputy Directors.

11. CNOD proactively informs the future developments in relation to health and social care across Scotland and, in turn, seeks to improve outcomes for the people of Scotland through the contribution that policy and professional advisors within the directorate make to this wider agenda. Both internally and externally, the CNOD provides expert clinical and policy advice in relation to all aspects of NMAHP/HCS, Regulation of Healthcare Professionals, and Healthcare Associated Infection (HAI) /Antimicrobial Resistance (AMR).

12. CNOD is responsible for:
    - Providing policy and professional advice to Ministers on matters relating to the education and workforce development of the professions for which CNOD have leadership, HAI/AMR, Professional Healthcare Regulation and also wider strategic and policy aims for the various professions within our remit
    - Overseeing the current student nurse, midwife and paramedic intake on an annual basis
    - Maintaining visible professional leadership and providing quality advice within Government and within the wider health and social care system in Scotland and the UK on issues relating to nursing, midwifery, allied health professions and healthcare science
    - Leading on all professional and policy aspects of healthcare-associated infection policy and antimicrobial resistance
    - Leading on Professional Healthcare Regulation including matters relating to Scotland's interests in overarching UK-wide reform of professional healthcare regulation
    - The successful implementation of the Health and Care (Staffing) (Scotland) Act 2019, which is being delivered in partnership with the Healthcare Staffing Programme operated by HIS and the Safe Staffing Programme operated by the Care Inspectorate. The Act will support Scotland's health boards and care services to have the right number of staff in the right place. Implementation of the Act was paused because of Covid-19.

13. As CNO, I exercised my responsibilities by providing professional advice and briefings. Advice was provided particularly through attendance at meetings. The groups I attended or was associated with are as follows:
    - The Health and Social Care Management Board (HSCMB). This is essentially the main decision-making body for health and social care delivery before, during and after the pandemic and was attended by me and the two preceding CNOs
    - The CNOs for each of the United Kingdom's four nations would meet to share knowledge and information as well as seek consensus on relevant matters and was attended by me and the two preceding CNOs. This was established during Fiona McQueen's tenure as CNO. An example joint statement relating to guidance on critical

care nursing is provided: [AMM2/001 - INQ000228362, AMM2/001a - INQ000227427, AMM2/001b - INQ000228364]

- The Scottish Executive Nurse Director (SEND) Group meeting was a forum where the CNO met with the territorial and national Board SENDs and discussed professional matters and to share information and was attended by me and the two preceding CNOs. SEND had been established for significant number of years before the pandemic.

14. During my tenure, my advice has largely been on nursing and midwifery professional practice and workforce numbers, professional healthcare regulation, and healthcare associated infections (HCAI) in relation to protective and interventional measures such as those that happen when infection outbreaks occur within a hospital setting, including guidance on what Personal Protective Equipment (PPE) should be worn. There have been wider issues upon which I have given advice, given my role within the HSCMB and the requirements of the pandemic response, which will be detailed below.

15. During the specified period, as required by my role as CNO, I provided advice to the SG and associated relevant decision-makers within the healthcare system with regards to the Covid-19 pandemic response.

16. I continued to provide professional leadership to Executive Nursing Directors in this sphere during the recovery phase of the pandemic.

17. I used the HSCMB and formal and informal directors' meetings, which would include the Chief Medical Officer (CMO), National Clinical Director (NCD) and CNO, to comment on the clinical interests of the nursing and midwifery profession to ensure that the whole management team were aware of and could take note of my advice. This would include pre-digest papers in which comments and views on behalf of Nursing professions would be fed in, which would be shared with all directorate colleagues.

18. DG HSC line-manages the Health and Social Care Directors including me as CNO. The DG HSC delegates financial responsibility for budgets and expenditure incurred against these budgets to individual Directors through the Scheme of Delegation.

19. My objectives were set each year with the DG HSC and appraised both mid-year and at the end of the performance year, with one-to-one meetings monthly to discuss delivery against

objectives and wider performance issues. In addition, I attended meetings within DG HSC at official level - these are routine and regular interactions within Government as part of regular governance (namely HSCMB, Health and Social Care Assurance Board (HSCAB), and Ministerial portfolio meetings).

Engagement with external organisations

NHS National Services Scotland (NHS NSS)

20. CNOD is linked to NHS NSS via their Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) team, who hold and maintain the National Infection Prevention and Control Manual (NIPCM).

21. I undertook monthly meetings with the Executive Nurse Director of NHS NSS to share information and intelligence relating to localised board as well as any matters of national interest and learning.

Nursing and Midwifery Council (NMC)

22. The NMC engages with the four nation CNO's on a monthly basis. Either I or a relevant professional advisor attended on behalf of the SG, a practice that continues to present day.

Royal College of Nursing Scotland (RCN), Royal College of Midwives Scotland (RCM), Health and Social Care Professions Council (HCPC) and NHS Scotland bodies and organisations

23. I undertook relevant conversations with the RCN, to receive intelligence in advance on any announcements being made with regards to workforce and professional nursing matters. The CMidO had responsibility for engagement with the RCM, given the CMidO's professional leadership role. As CNO I attended the monthly NHS Board Chief Executive and Chairs meetings to communicate any matters of professional relevance. The areas of discussion focussed on the staffing absence which was led by Workforce as well as the implications of staffing absence in delivery of Infection Prevention Control (IPC) guidance. The conversations with the RCN focussed on wellbeing concerns for staff and I took opportunities to highlight the various wellbeing measures that had been implemented which was led by Health Workforce and detail provided within the statement of Fiona McQueen.

Engagement with CNOs for England, Wales and Northern Ireland

24. The CNOs for Scotland, Wales, Northern Ireland and England met virtually on Microsoft Teams; these took place on a weekly basis during the relevant time period to share knowledge and information as well as seek consensus on relevant matters. This was the main engagement with other CNOs. I found this to be a productive forum to gather intelligence and further develop my understanding of the wider UK position on Covid-19 response, as well as other issues. The issues that were discussed focussed on building staffing capacity including the temporary register extension and the use of students within the workforce and implications of the wider nursing pipeline.

CNO involvement in national and local guidance

25. As Director of CNOD, I worked with NHS Boards to manage and reduce the number of hospital onset cases of Covid-19 through the implementation of robust IPC measures. This included measures such as the appropriate use of PPE, the extended use of face masks and face coverings, physical / social distancing, ensuring optimal ventilation, enhanced cleaning measures in high-risk pathways, systematic outbreak management, healthcare worker (HCW) testing and patient admission testing to ensure patients were placed in the appropriate pathway.

26. Health Facilities Scotland (HFS) provided evidence and guidance on ventilation to the Covid-19 Nosocomial Review Group (CNRG). It was the responsibility of ARHAI Scotland to incorporate the evidence into national guidance.

27. Any change to IPC measures in Scotland was based on the best available scientific evidence, expert opinion and consensus at that time. To the best of my knowledge, the only exception to this is the offering of Respiratory Protective Equipment (RPE) because of a health or social care worker's personal preference. This was not based on the IPC evidence base and, as such, was not an IPC measure. The personal preference of RPE was offered as a SG Workforce policy in March 2022.

FFP3 guidance

28. The First Minister first raised her preference that HSC staff should have discretionary access to FFP3 masks in response to a submission on this topic on 13 January 2022. This was in response to concerns raised by some stakeholders and staff within the NHS. Further meetings took place between SG officials and Ministers between January 2022 – March 2022. During this time, officials in CNOD were leading on advice and progress updates to Ministers and coordinated high level meetings throughout with a variety of internal and external stakeholders.

However, after our discussions with the First Minister, the decision was made to allow access to FFP3 masks based on personal preference, Health Workforce colleagues oversaw the drafting and publication of the Directors Letter. Health Workforce colleagues drafted and updated the guidance after consulting with a variety of internal and external stakeholders including clinicians and unions. On 25 March 2022, Health Workforce colleagues sent a progress update to Ministers. This noted that officials were working on guidance to allow discretionary access to FFP3 facemasks for all frontline staff during the transition period, and that work was ongoing with social and primary care to provide discretionary access to FFP3s in these areas, such as in care homes or GP practices. The final decision on this guidance was made via submission to Ministers on the 14 April 2022 [AMM2/019 - **INQ000378260**, followed by the signing of the Directors Letter prior to final publication on 19 April 2022 [**AMM2/006** - INQ000429256].

29. Additional modelling was undertaken on the supply of FFP3 masks, however it was not anticipated that demand would be high, based on zero uptake of FFP3 masks when they were included in the HSC worker self-isolation exemption that was in force from July 2021 to January 2022.

30. CNOD was aware of issues around the fitting of PPE, including face fitting of specific types of face masks during the pandemic. This included staff with smaller and differing physiological face shapes, particularly women, ethnic minorities and people who had facial hair (including for religious reasons). CNOD worked with officials in the PPE Directorate to ensure there were a variety of PPE options available to staff.

31. The CNOD HAI/AMR Team was also responsible for the drafting and publishing of extended use of face mask guidance, as set out below for my time in post.

IPC Guidance Timeline

Date of	Change	Description of Change	Reason for Change

Change			
January 2022	Further updates to the Winter Respiratory addendum. [AMM2/002 - INQ000322611]	Reduction of Covid-19 duration of precautions from 14 days to 10 days. Update to Non Covid-19 discharges (non-respiratory pathway) from hospitals to care homes. Addition of sections for primary care and care homes to reinforce and support assessment using the hierarchy of controls.	Update based on review.
February 2022	Further updates to the Winter Respiratory addendum. [AMM2/013 - INQ000410989]	Additional information for visitors entering Aerosol Generating Procedures (AGPs) zones.	Update based on review.
March 2022	Covid-19 IPC measures in Health and Social Care settings. [AMM2/014 - INQ000429280]	De-escalation of Covid-19 IPC measures in Health and Social Care settings.	To support remobilisation of services and meet the needs of a wider cohort of patients.
April 2022	Further changes to the Winter Respiratory addendum. [AMM2/013 - INQ000410989]	• Changes to management of contacts including inclusion of 28-day contact exemption • Changes to respiratory screening questions • Withdrawal of car sharing guidance • Update to include definition of fully vaccinated • Addition of testing responsibilities at an	ARHAI Scotland made several recommendations aimed to reduce pressures on NHS Boards, highlighting lessons learned during the pandemic, and recognising Covid-19 as a pathogen that will require management, to

		organisational level and clarity of testing language • Change to isolation advice for service users with Covid-19 • Removal of vaccination as part of contact management • Closure of the ARHAI Scotland Rapid Review - Assessing the IPC measures for the Prevention & Management of Covid-19 in Health & Care Settings V25.0, as agreed at CNRG.	varying degrees, health, and care settings. CNRG endorsed the amendments.

Provision of Information

32. I was not involved in the translation and interpretation of guidance for maternity services between January-June 2022. This is in the professional remit of the CMidO.

33. I worked closely with the Health Workforce Directorate (HWD), providing clinical and professional advice across a number of their policy areas. The remit of the HWD during the pandemic was as follows:

- Delivery of the Test and Protect workforce
- Delivery of the Vaccinations workforce
- Innovation around Wellbeing support
- Amendments to NHS Terms & Conditions
- Partnership relations with unions and professional bodies and NHS Employers
- A range of employee / employer Covid guidance for the NHS
- Supporting health boards in relation to the redeployment of staff to essential clinical roles
- Supporting additional recruitment including of staff returning to the service
- Working with NHS Education for Scotland (NES) and higher education partners to address key strategic issues and risks around healthcare student placements
- Supporting the deployment of students into the workforce.

34. HWD shared vast amounts of information and guidance with NHS Scotland leaders, including NHS Chief Executives, Chairs, Human Resource Directors and Employee Directors and Executive Medical and Nurse Directors. Distribution lists were extensive and kept up to date to ensure information was available to health boards at the earliest opportunity. There were no issues raised with me directly around the dissemination of information.

Testing for nursing staff and midwives

35. CNOD were the policy leads responsible for asymptomatic healthcare worker Covid-19 testing using both Polymerase Chain Reaction (PCR) and Lateral Flow Device (LFD) tests; this was inclusive of healthcare assistants and midwives. Therefore, I had a role in the maintenance of these policies. I was only involved in the testing policy from October 2021 to June 2022.

36. For instance, in December 2021 the frequency of LFD testing for healthcare workers increased in frequency from twice weekly to daily testing. This was in response to emerging evidence that the Omicron variant had a higher rate of transmission than other variants. This reverted to twice weekly testing in February 2022 based upon a reduction in Covid-19 prevalence in the community as well as a reduction in the number nosocomial clusters. Further information on this can be found within Fiona McQueen's statement to Module 3 of the UK Covid-19 Inquiry.

37. In January 2022, HWD colleagues also provided an update to the self-isolation for health and social care staff policy which introduced LFD testing to release previously Covid-19 positive health and care staff from self-isolation early, after seven days of isolation if they had two consecutive negative LFD test results. This allowed staff to return to work earlier than the coindicated ten days.

38. In summary, Covid-19 testing of healthcare workers both facilitated and hindered healthcare worker availability. The aim of the programme, however, was to stop nosocomial transmission and protect those accessing healthcare from the harms caused by Covid-19. A timeline of changes to healthcare worker Covid-19 testing from my time as CNO during the relevant period is provided below.

Healthcare Worker (HCW) Covid-19 Testing Timeline

Date of Change	Change	Description of Change	Reasons for Change
December 2021	LFD testing frequency for HCW, Primary Care, and Independent Contractors. [AMM2/015 - INQ000477441] Move from Innova 25s/OG7s to Orient Gene 20s.	Increased LFD testing frequency from twice weekly to daily testing. Staff should continue to use LFD testing within 90 days of a positive PCR result. If the member of staff has a positive LFD result or has new symptoms, they should isolate and take a PCR test. The updated Policy Framework also states that if a staff member declines daily LFD testing, they should not return to work in a physical setting and instead should work from home during the 10-day isolation period.	In response to emerging evidence that the Omicron variant has a higher rate of transmission than other variants.
January 2022	Further updates to the Winter Respiratory addendum. [AMM2/002-INQ000322611]	All positive Covid-19 cases can exit self-isolation on day 7 regardless of vaccination status if they have a negative LFD test on day 6 and day 7 (taken 24 hours apart), and do not have a fever (for the previous 48 hours without the use of anything to reduce a fever).	In response to early identification of Omicron cases. This variant has a higher rate of transmission than other variants.

		Unvaccinated or partially vaccinated contacts (0-2 doses) are asked to take a PCR test. This was regardless of the result and to isolate for 10 days, from exposure to the case.	
February 2022	LFD testing frequency for HCW. [AMM2/016 - INQ000477438]	Reverted to twice weekly for LFD testing.	The return to twice weekly LFD testing is based upon a reduction in Covid-19 prevalence in the community as well as a reduction in the number nosocomial clusters. The CNRG considered and are supportive of HCWs moving from daily to twice weekly LFD testing.
May 2022	Further Updates for Healthcare Professionals - Affecting staff testing, and amendments to guidance. [AMM2/017 - INQ000477439]	• Updates to hospital testing table - advising PCR or Point of Contact Testing can be used to support risk assessment • Document outlining transition content from Winter Respiratory Addendum to NIPCM, which included removal of patient pathways • Development of Appendix 21 - outlining specific Covid-19 IPC pandemic controls for secondary care • Updates made to Appendix 19: Elective	Following agreement and advice of the CNRG.

		surgery IPC principles. Reflecting the changes made as part of the transition process including removal of references to respiratory pathway and links to Covid-19 appendix rather than the addendum • Update made to Appendix 21 - Reference to Covid-19 screening removed.	

39. As set out above, self-isolation guidance after a positive test was the remit of HWD colleagues although CNOD worked closely with them and provided clinical advice as well as issuing joint letters with Director of Health Workforce and CMO on some updates to guidance for health and social care staff.

40. The timeline for respective changes to guidance is provided in the table that follows, which shows changes to self-isolation exemptions guidance for health and social care staff as a result of changes to the Covid-19 self-isolation guidance for the general population.

Date of changes	Version	Overview of change
05/11/21	Version 7	DL (2021) 36 – Quarantine (Self-isolation) for NHS Scotland staff returning to the UK, provided: [AMM2/003 - INQ000470087]. 1) Staff traveling abroad are encouraged to check Covid-19 infections rates in any potential destination and should do this in the full awareness that the status of their destination may change at short notice either in the run up to or during their trip.
24/12/21	Version 8	DL (2021) 50 – Update on Self-isolation for Health and Social care staff, provided: [AMM2/004 - INQ000469957]. Updated Policy Framework states that if a staff member declines daily LFD testing, they should not return to work in a physical setting and instead should work from home during the 10-day isolation period. This applies even if the member of staff cannot fulfil their role from home. 2) It also clarifies that staff are advised that they should also follow the SG guidance on isolating after the initial close contact, when they are not at work or carrying out work related activities.
06/01/22	Version 9	DL (2022) 01 Update on Self-isolation for Health and Social care staff,

		provided: [AMM2/018 - INQ000477440]. 1) All index (positive) Covid-19 cases can exit self-isolation on day 7 regardless of vaccination status if they have a negative Lateral Flow Device (LFD) test on day 6 and day 7 (taken 24 hours apart) and do not have a fever (for the previous 48 hours without the use of anything to reduce a fever). 2) Unvaccinated or partially vaccinated contacts (0-2 doses) will be asked to take a PCR test and regardless of result will be asked to isolate for 10 days, from exposure to the case.
17/01/22	Version 10	DL (2022) 01 Update on Self-isolation for Health and Social care staff, provided: [AMM2/005 - INQ000469958]. 1) Fully vaccinated staff (those who have had two doses and a booster 14 days prior to the last exposure to the case), identified as either household or non-household contacts will be expected to take daily LFD tests for seven days, from exposure to the case and if the LFD tests are negative and they remain well, will not have to isolate. They can also end further contact testing at the end of the 10-day period.
24/01/22	Version 11	DL (2022) 01 Update on Self-isolation for Health and Social care staff, as provided in the row above. 1)The revised policy document sets out the conditions that allow Health and Social Care staff who are isolating as a Covid-19 index case to leave isolation in seven days, in line with the general population advice. Re-affirms the guidance that is in place which allowed Health and Care Staff who are close contacts (household and non-household) to return to work when certain conditions are met.
19/04/22	Version 1	DL (2022) 10 Health and Social care worker access to FFP3 masks, based on staff preference during the transition period. The rationale is provided with the DL, provided: [AMM2/006 - INQ000429256].

41. From December 2021 colleagues in the Health Workforce Employee Experience Unit were given responsibility for this guidance. From December 2021 to April 2022 the guidance was commonly referred to as 'self-isolation guidance'. This covers two publications provided in the table above (AMM2/04 and AMM2/05).

42. From April 2022 to present day, the guidance was referred to as 'managing respiratory infections' guidance. This covers the two publications provided: [AMM2/007 - INQ000324683], [AMM2/008 - INQ000147373].

Staffing

43. The initial decisions taken to establish the temporary register was led by Fiona McQueen and I would refer you to her statement. Further decisions around extension to the register were led by the NMC but all four CNO's were engaged in the process. Ministers were sighted following communication from the NMC. No concerns about the temporary register were raised with me during my tenure.

44. In addition to this, the significant work around bolstering the workforce during the pandemic would have been undertaken by Fiona McQueen. The annual student intake process sits within my policy remit, and this intake process was well established before the pandemic.

45. I have been asked about any concerns raised regarding the prevalence of long Covid amongst nursing and midwifery staff. Again, this would be managed through HWD and not CNOD. I was certainly aware through informal discussions and press coverage that concerns were being raised by individuals or their professional bodies in respect of long Covid and I was aware of the initial support being made available through SG to support these individuals.

46. As CNO, I spoke with Nurse Directors at the monthly CNOD SEND meetings and the SG's Health Workforce Director at monthly catch ups on staff absence. There were no issues raised as part of those conversations that led to any policy change during the relevant period.

47. Matters relating to the redeployment of staff were the remit of HWD and as such I was kept informed of updates but otherwise was not directly involved.

48. I undertook several visits across territorial Health Boards including NHS Fife on 16 February 2022 and NHS Forth Valley on 16 March 2022, where I took the opportunity to engage with staff first hand to hear the impact of Covid-19 on the mental health and well-being of nursing staff and midwives. Whilst there were concerns raised around staffing capacity and fatigue due to mass pressures on the service, there were no significant issues raised which changed any further policy support already provided by SG.

Maternity Services

49. A number of the decisions taken with regards to maternity services were taken before I took on the role as CNO. I would refer you to the statement of Fiona McQueen. The CMidO has professional oversight and would provide significant clinical and professional advice on matters relating to maternity and paediatric services.

50. With regard to access for partners, visitors and other supporters, I was not aware of any concerns raised. These would have been directed towards the CMidO or the Directorate for Children and Families within Scottish Government.

51. I was also not aware of any concerns raised about inequalities in maternity services. Again, those would have been directed towards the CMidO or the Directorate for Children and Families within Scottish Government.

Infection prevention and control measures

52. CNOD is responsible for communicating updates to HAI and IPC guidance to NHS Scotland Boards. However, CNOD did not directly produce IPC advice or guidance. Further information on IPC measures is available in Fiona McQueen's statement, I do not have further reflections to usefully add.

53. CNRG provided the relevant advice to CNOD with regards to reducing the risk of nosocomial transmission of Covid-19 via healthcare worker testing. In February 2022, due to the reduction of Covid-19 nosocomial clusters, officials sought advice from the CNRG to consider whether daily asymptomatic testing of HCWs was still necessary. The group offered their expert advice on this issue and were supportive of reverting to twice weekly testing as soon as practical.

PPE and RPE

54. The CNOD HAI/AMR Policy Team was responsible for drafting and updating guidance on the extended use of face mask guidance in adult hospitals and care homes for the elderly, which was first published in June 2020, provided: [AMM2/009 - INQ000343816]. I was only involved from October 2021 to June 2022. I discuss the changes below. Further information on this guidance is provided in Fiona McQueen's statement, I do not have further reflections to usefully add.

55. The extended use of guidance for the wearing of face masks and face coverings was withdrawn in June 2023 with the recommendation to revert to the NIPCM. I believe this was a proportionate approach which recognised that Scotland was adapting to the Covid-19 pandemic and had entered a calmer phase of the pandemic. Any change to the extended use of face masks and face coverings guidance was in relation to the latest scientific evidence and was kept under continual review.

56. Guidance on RPE was within the remit of ARHAI Scotland, although the SG communicated it to the health service.

57. A SG policy was introduced in March 2022 which offered health and social care staff access to FFP3 respirators if they wanted to wear one. This was a workforce policy introduced because of ministerial decision making and did not follow a specific change in evidence. This was a Scotland-only policy and was not replicated in the rest of the UK, with colleagues in HWD drafting this policy. The relevant Directors Letter is provided: **AMM2/006** - INQ000429256].

58. To the best of my knowledge, I do not believe any issues were raised with regards to matters of testing and assessing the adequacy of PPE and RPE between January and June 2022.

59. To the best of my knowledge, I do not believe any issues were raised with regards to shortages of PPE and RPE for nursing staff and midwives between January and June 2022.

Inspection of healthcare settings by Healthcare Improvement Scotland (HIS)

60. I cannot comment on the original suspension of HIS acute hospital inspections during the pandemic. I refer you to Fiona McQueen's statement.

61. On 5 November 2021, the Cabinet Secretary for Health and Social Care signed off a proposal to temporarily adopt an amended model of hospital inspection that is primarily focused on safety and Covid-19. This amended model is still in place, although it was updated in March 2023, to expand the methodology used by inspectors to include HEI tools and standards. In adapting the inspections, HIS inspection teams carried out as much of their inspection activities as possible through observation of care and via virtual discussion sessions, as opposed to the wholly in person approach that was taken previously. This change sought to minimise requests on frontline staff over the course of the inspection. This was led by Healthcare Quality and Improvement Directorate but was discussed with CNOD. CNOD was assured that IPC measures would be strictly observed.

Visiting restrictions in hospitals

62. SG clinical advisors including those from CNOD provided IPC advice to the SG Visiting Team but were not directly involved in producing guidance on visiting.

63. From October 2021 to April 2022, Healthcare Quality Improvement Directorate (HQI) within DG HSC led on the development of detailed guidance and principles to support Scottish health boards to manage hospital visiting during the pandemic.

Lessons learned

64. CNRG completed a formal review of the CNRG response to Covid-19 to inform future preparedness in November 2022, provided: [AMM2/011 - INQ000322605]. This review considered the delivery against the agreed remit and scope of CNRG, highlighting lessons identified for future preparedness in delivery of the CNRG objectives. Wider system learning, as part of the CNRG considerations, was also covered and recommendations made for wider future pandemic preparedness and IPC strategy.

65. The recommendations of this review included retaining a Terms of Reference (TOR) (including membership) for future pandemic responses and creating formal TORs for specific subgroups (such as testing, IPC, surveillance, built environment and behavioural insights), formalising links to workforce groups and Unions; establishing links to academic and experts to enable learning; enabling access to real time information from the Scientific Advisory Group for Emergencies (SAGE); retaining nosocomial data, intelligence and evidence review functions of ARHAI; maintaining and developing cluster reporting system software and methodology; reviewing ARHAI nosocomial surveillance systems and developing protocol for rapid development of a new system, when required; developing occupational health systems to provide better healthcare (HCW) data intelligence; healthcare associated infection (HAI) whole genome sequencing (WGS) requirements and protocols to be specified and developed for future pandemic HAI outbreaks, including identification of HCW samples; developing WGS to support HAI outbreaks in real time and building infection prevention and control teams capacity and capability to utilise this technology; developing framework to support boards to utilise IPC indicators; investment in IPC research; establishing formal ARHAI reporting structures to support SG; mapping national groups with interest or influence in nosocomial to optimise communications; developing user focussed IPC guidance while balancing harms of wider

workforce and learning from behavioural insights work; considering how IPC is played into future pandemic preparedness exercises; seeking international consensus on transmission terminology to assist with communications; consideration of bed spacing, ventilation, isolation capacity and other IPC measures to allow optimisation of existing NHS Scotland estates, while considering future refurbishment and building; and consideration of future IPC preparedness against that described in World Health Organisation (2021) Framework and toolkit.

66. CNOD is progressing work in relation to those lessons identified and areas for further work provided by CNRG, plus a review of the location in the public health landscape of ARHAI Scotland as previously agreed by the Cabinet Secretary for Health and Sport at the time, Ms Freeman. The terms of reference of the ARHAI Scotland's location review are provided: [AMM2/012 - INQ000339584].

67. The main forum for gathering feedback, learning and information from leaders in the nursing profession is the SEND group which holds regular meetings. This forum was established several years ago where CNO meets with the SENDs to discuss professional matters, such as staffing concerns and feedback on policy implementation This provides a forum for the SENDs to share information, such as staffing and capacity challenges in a safe and trusting environment. I have utilised the SEND forum. The CMidO, CAHPO and CSO operate similar fora with their respective professional leaders within the Boards.

Other matters within the Scope of Module 3

68. Due to the date in which I took up post, I was not involved in many of the decisions made. This includes the increase of technology for patient consultations, the suspension of elective surgery and diagnostic screening programmes and the establishment of risk based clinical pathways.

Statement of Truth

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

Signed: **Personal Data**

Dated: 3 June 2024