Witness Name: ROBIN SWANN, MLA
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF:
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Minister of Health (11 January 2020 – 27 October 2022)
Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY
MODULE 1 RULE 9 REQUST – REFERENCE M1/RS
DEPARTMENT OF HEALTH (NI)

Contents

WITNESS STATEMENT OF ROBIN SWANN

1. I, Robin Swann, former Minister of Health for Northern Ireland, make this statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry"), dated 15 February 2022 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 1.

Scope of this statement

2. This statement is provided from the perspective of my former role as Minister of Health in relation to the Department of Health's planning and preparedness for health emergencies in Northern Ireland. It is important to emphasise that I was appointed Northern Ireland Minister of Health on 11 January 2020, a few short weeks before the start of the pandemic and that my term in office ended on 27 October 2022. My insight into technical details of pre-pandemic preparedness is therefore limited.

3. The Covid-19 virus represented the biggest threat to public health since the conception of our National Health Service.

4. Many people lost their lives in Northern Ireland, across the UK, and across the world. So many families were left grieving. Those who were lost and those who mourn them must be at the forefront of our minds in any assessment of how Governments responded to the pandemic. We must never forget the toll that Covid took.

Pandemic Readiness

5. General Pandemic readiness was referenced in my First Day Brief [INQ000188802] but at that point, the issue was not a primary focus of attention, as there was little awareness of the news emerging from China about the new virus. Moreover, the more pressing matters at the date of my appointment were the deep concerns about ongoing industrial action by our health service workers and a range of very significant pressures weighing down on the local health service.

Operation Cygnus

6. I received a submission from Department officials in October 2020 which advised me about Operation Cygnus [INQ000188803]. On the basis of what was provided to me I believe that the 2016 simulation exercise Operation Cygnus, which was a cross-

governmental exercise to test the United Kingdom's response to a serious influenza pandemic, assisted in identifying gaps in the levels of United Kingdom preparedness. It was important that Northern Ireland participated in this exercise, not only from a United Kingdom wide perspective, given the almost inevitability that any pandemic would require significant Four Nation interworking, but also so that local preparedness and structures were robust. I understand that the simulation exercise gave rise to continued engagement on a Four Nations approach on planning for a pandemic and continuing cooperation with colleagues across the United Kingdom in implementing lessons learnt which could be applied across a range of health and social care emergencies where they affect, or have the potential to affect, Northern Ireland.

7. Having witnessed the rapid establishment of the various decision-making levels across the Health and Social Care system in Northern Ireland, such as the Gold, Silver and Bronze bodies I was satisfied that they operated with appropriate speed and priority. Further work to build resilience and increase emergency preparedness following Cygnus was undertaken by the Department which provided a good foundation for action during the Covid-19 pandemic. Exercise Cygnus focussed on the UK response to a flu pandemic near the Reasonable Worst-Case Scenario. Not all our plans to respond to a flu pandemic could be used for the COVID-19 response, although in some cases they provided a good foundation for action. This is because it was a new and different virus and required a slightly different response. Where pandemic flu plans [INQ000185380] could be used they were deployed, for example:

- Previous learning on reducing the risk of transmission through good infection prevention and control practices were employed e.g., hand and respiratory hygiene advice (e.g., *'Catch it, bin it, kill it'*);
- Using the Pandemic Flu Bill draft legislation to support the response to a future influenza pandemic as a starting point for the development of the Coronavirus Act, which supported thousands of retired healthcare workers across the United Kingdom returning to the frontline to help battle the COVID outbreak.
- Previous learning on activating Surveillance and modelling.

The Northern Ireland Context

8. I believe it is important to consider the context of early 2020. There had been no functioning Assembly or Executive in place for over three years. Departments were without Ministers for the entirety of this period and the legal decision-making ability of

the senior Northern Ireland Civil Service was very limited. Even before 2017, the political environment in Northern Ireland had often been unstable.

9. On the 14 May 2020 when I addressed the Northern Ireland Assembly's Ad Hoc Committee on COVID-19 [INQ000185381] I highlighted key areas where I believed collective past political/Governmental failings left health and social care vulnerable to the pandemic. I believed then, and still do, that over the previous decade Stormont had let the NI Health Service down by not looking after health and social care as well as it could and should have done. It is my view that whilst Health was a devolved matter during this period, there was very limited local control over finances, vital services were underfunded; short term decisions were made instead of longer-term planning and difficult decisions were avoided. Social care was particularly neglected with a lack of proper pay and career structures, leaving our care homes exposed.

10. Underfunding and persistent single year budgets saw healthcare surviving hand to mouth, with a limited ability to plan strategically and deliver better services. The annual setting of single year budgets, which were sometimes only finalised months into the financial year, led to retrograde short-term decisions being taken. As health and social care ran on close to empty for 10 years, it meant that there was limited capacity, resilience or flexibility when it was needed most. Accordingly, when the pandemic struck, we were left with no option but to do our best to free up capacity and procure essential equipment at pace.

11. I remain of the opinion now that the lack of a recurrent budget had an adverse effect on the readiness of public services to prepare for a whole-system civil emergency. The Department of Health has been faced with single year budgets since 2015/16. With single year budgets the funding position is only known for 12 months which means the focus is on the short term. When single year budgets are coupled with funding provided on a non-recurrent, or single year basis the position is exacerbated as you cannot make commitments over a number of years with no funding guaranteed. This had impeded long term financial planning and resulted in a focus on the short term. All recurrent funding received by the Department in recent years had been used to fund the costs associated with maintaining existing models of service and associated cost pressures. Single year injections of transformation funding, whilst successful in part, were not sufficient to embed the systemic change required due to their short-term nature. A recurrent multi-year funding commitment would have better supported the planning, delivery, and sustainability of our services. It would have also enabled us to develop plans to transform our services fully given

that a multi-year budget guarantees funding over a number of years which enables long term planning and the ability to enter into commitments over a number of years as the funding has been assured.

The Civil Contingencies Framework for NI

12. The Civil Contingencies Framework for NI (2011) [INQ000185382], published by the Executive Office (NI), required the Department to maintain, review and update its Emergency Response Plan and to test and exercise the plan response arrangements. This was to ensure the Department's ability to deliver an effective response to minimise the health impacts of any emergency on society for which it had been the designated Lead Government Department. I would also note that at that time The Civil Contingencies Framework for NI had not been updated from 2011 (although it was subsequently updated in 2021.

13. Northern Ireland officials across several Executive Departments and relevant statutory agencies were able to respond at pace in implementing the emergency powers legislation and the provisions therein. I believe that further awareness of the roles and responsibilities of other Departments about the emergency powers legislation, as well as improved mechanisms to streamline the timely dissemination of information following decisions would be beneficial across all Northern Ireland Civil Service departments.

Effectiveness of the Pre-Pandemic Work

14. As much of the work on pandemic planning, preparedness and resilience took place before I took up office it is difficult for me to comment on the efficacy of the systems, processes and structures that were put in place. However, I do know that the experience of the Chief Medical Officer with H1N1 helped inform the COVID-19 responses of the Department of Health and NI Executive.

15. As mentioned in para (6), following Operation Cygnus, work was undertaken by the Department to build resilience and increase emergency preparedness, and this experience was used during the pandemic when the Department of Health sought to embed learning from each wave of the COVID-19 pandemic to help inform subsequent surge planning. The Health Gold Command was stood up in March 2020 and a number of cells were established as part of the Emergency Response, for example, "Supplies Cell" and a "Workforce Cell" [INQ000185383].

16. A number of other cells [INQ000185384] were created outside of Health Gold Command as part of the Department's 'business as usual' pandemic response for example, a Nosocomial Support cell was created in December 2020 to ensure a full and comprehensive understanding of COVID-19 infections, clusters and outbreaks as they occurred in acute settings. The benefits of these cells included the ability to enable quick and effective sharing of lessons learned and associated implementation of best practice across all Trusts to reduce nosocomial spread [INQ000185385]. Nosocomial Infections are infections that are acquired during the process of receiving health care that were not present during the time of admission.

17. Other examples of cells include Clinically Extremely Vulnerable (CEV), Contact Tracing, Cancer Services, Infection Prevention Control (IPC), Personal Protective Equipment (PPE), Unscheduled Care. Each of these cells brought focus and a sense of agility of responsiveness throughout the course of the pandemic.

18. Embedding learning in this manner helped inform subsequent planning with the publication of a Surge Planning Strategic Framework (September 2020) [INQ000185386], the development of a regional critical care plan, as well as the utilisation of capacity across the Northern Ireland independent sector hospitals.

19. I recall that in the margins of meetings there was a discussion about the possibility that a Table Top exercise would be carried out in the summer of 2020, which would draw from lessons learnt across all departments, and that this could be used to prepare for a potential autumn wave of COVID-19. My understanding was that this Table Top exercise may have been suggested by either the Head of the Civil Service or colleagues in The Executive Office (TEO). My recollection was that this exercise had been mooted to happen during summer 2020, however this was postponed to later in the autumn after summer recess. Ultimately the Table Top exercise did not happen. The reasons for this are unknown to me. This I believe was a missed opportunity for a joined-up approach that would have involved all departments.

Decisions taken during my tenure

20. As stated above, I was appointed Northern Ireland Minister of Health on 11 January 2020 and key financial and policy decisions, impacting the pandemic planning, preparedness and the resilience of public services, were taken in the preceding years. However, I would like to highlight some decisions which, in my view, were crucial to support our pandemic response.

Activation of Contingency Structures

21. I consider that the activation of the Department of Health's contingency structures worked well. I would highlight the Gold/Silver/Bronze command structure which was established to stratify decision making and to ensure effective communication. In my view, the approach of establishing "cells" to 'take responsibility' for critical priorities was effective in ensuring the Department of Health's attention was focused on the right issues. Each policy cell was responsible for monitoring the impact of the pandemic in specified service delivery/policy areas, responding to issues escalated to Health Gold by Silver and developing new policies or responses designed to mitigate or address the difficult, novel, and complex issues faced by the Health and Social Care system, as the impact of the pandemic began to take hold and became pervasive across health and social care.

22. I would also point to the Emergency Operation Centre (EOC) which was established as an effective model for ensuring continuous operational awareness for the Department of Health and the wider HSC. The Emergency Operation Centre was activated on 27 January 2020 in response to the emerging threat of Covid-19. Information boards were quickly established in the Emergency Operation Centre to aid decision-makers and to assist in managing the flow of information into and out of the Emergency Operation Centre. These information boards were continuously monitored and maintained throughout the duration of the emergency response phase.

Maintaining purchasing systems through Business Services Organisation / Department of Finance

23. On 12 May 2020 as Minister of Health I approved the proposal for the Business Service Organisation ('BSO') to proceed with the establishment of a Dynamic Purchasing System (DPS) for personal protective equipment (PPE), [INQ000185387]; [INQ000185458]; [INQ000185459]. A Dynamic Purchasing System is a procedure available for contracts for works, services and goods commonly available on the market and was set up under Regulation 34 of the Public Contract Regulations 2015. A Dynamic Purchasing System, unlike a traditional framework, allowed the Business Services Organisation to work with suppliers with much more agility and speed. It was designed to allow the Health and Social Care system access to a pool of checked and pre-qualified suppliers, thereby greatly reducing avoidable delay.

24. Subsequently, on 25 June 2020 a Departmental Direction was issued to Business Service Organisation, enabling the setting up and administration of a Dynamic Purchasing System for personal protective equipment [INQ000185391]. In consequence of this the Business Service Organisation managed the development of a personal protective equipment Dynamic Purchasing System arrangement, both for their own use, and that of the wider Northern Ireland Public Sector. The Central Procurement Directorate in the Department of Finance (DoF) concurred that, given their expertise regarding personal protective equipment products, it was logical that the Business Services Organisation should establish the arrangements on behalf of all. At the start of the pandemic Business Services Organisation were holding an additional six weeks stock, based on business-as-usual stock levels at the time, of a range of medical devices, clinical and non-clinical consumables. This was part of action taken to ensure that contingencies were anticipated in respect of possible supply chain disruptions related to EU exit. This stock contained Aprons, Gloves and T11Rs masks but did not include other items of PPE, such as FR Gowns, FFP3 Respirators and Face shields.

Support of domestic manufacturing for essential items for Health and Social Care

25. In the early stages of the pandemic, a key component of the Business Service Organisation procurement strategy was to maximise the opportunities to strengthen the local supply position to secure greater resilience and flexibility in the supply chain for the local HSC and to lessen the reliance on securing product internationally with a long lead in time. This approach mirrored the UK Government's MAKE initiative, which was designed to call on UK manufacturers to consider production of personal protective equipment for the NHS.

Military Aid to Civil Authority

26. In the period from February 2020 to January 2022, I activated Military Aid to Civil Authority (MACA) on behalf of the Department of Health on several occasions The nature of these activations included: the redistribution of mechanical ventilators and other equipment across Northern Ireland; the development of a temporary Nightingale facility [INQ000185392], [INQ000185460], [INQ000188810]; the transfer of a few patients to other hospital facilities in the UK [INQ000185400] and [INQ000188811], [INQ000188804], [INQ000185408], [INQ000185461] and [INQ000185462]; [INQ000185413] and [INQ000188812]; and, securing access to Combat Medical Technicians (CMTs) to provide both medical and non-medical

support across several hospital sites in Northern Ireland, [INQ000185417] and [INQ000185464]. In my view, this process worked very effectively, providing timely operational support at a crucial time for the health service.

Care home intervention and financial support

27. It was anticipated from an early stage that social care providers were going to be among the hardest hit by the pandemic. That is why, from the outset, key decisions were taken to protect and maintain the financial resilience of providers, not least those in the care home sector.

28. Significant additional funding was made available for independent sector providers of adult social care in 2020/21, consisting of three financial support packages amounting to £45m, alongside an income guarantee for Care Homes and significant support in kind.

29. As part of the early response to the pandemic it was recognised that there could be a significant impact on the ability to deliver services to care home users normally. Indeed, a number of Care Homes saw a significant reduction in the number of residents and in their ability to fill beds (for instance, because of isolation requirements or because families were reluctant to place relatives in homes) during the pandemic. A number of measures were therefore put in place to try to ensure key organisations remained viable. Early in the response to the pandemic the Health and Social Care Board proposed an income guarantee was introduced for Care Homes, ensuring that where income fell 20% below the previous three-month average then HSC Trusts should block purchase 80% of the vacant beds at the regional tariff. This was reflected at paragraph 4(f) of the 17 March 2020 guidance [INQ000185427]. The approach was later revised and amended to providing 96% of the pre Covid average payment in April 2021.

30. I announced on 27 April 2020 a financial grants support package amounting to £6.5m with individual Care Homes receiving a payment of £10k, £15k or £20k depending on their size [INQ000185428] and [INQ000185465]. This reflected feedback from the sector about the additional costs they were facing as they sought to implement additional Infection Prevention and Control measures. In order to ensure Care Homes were able to take these measures, additional funding was granted. A number of different mechanisms were considered, including increasing the Northern Ireland-wide bed rate set by the Health and Social Care Board. However, a one-off payment was deemed to reflect the temporary nature of the situation and the payments based

on bed sizes were seen as the most straightforward way to calculate this support, albeit it was recognised that this was not a perfect solution.

31. I announced further financial support packages of £11.7m on 2 June 2020 [INQ000185429] and [INQ000185472] and £27m in October 2020 [INQ000185430] and [INQ000185478]. These packages followed engagement with the Public Health Agency and Health and Social Care Trusts, advice from the Health and Social Care Board and close engagement with the sector (including engagement with individual providers, who provided detailed evidence of additional costs and year on year changes). The funding reflected many of the key issues set out in guidance to the sector and learning from each package of support (including low take up of some elements of the June 2020 package).

32. This money funded a range of issues, to include: enhanced sick pay to pay staff who received 80% of their salary when on sick leave for Covid-19 related reasons (ensuring sick staff did not feel financial pressure to attend work when they may be Covid-19 positive); additional PPE (with many Care Homes continuing to source items themselves); additional equipment, including thermometers, pulse oximeters (to monitor patients and staff for symptoms) and tablet devices to ensure online communication with families in the continuing absence of visits; staff training costs (for instance in Infection Prevention and Control); taxi costs for staff getting to work (rather than on public transport, where the infection risks were greater); reimbursing staff for one-off Covid-19 testing; essential IT infrastructure (e.g. to support virtual visits and remote consultations); additional environmental cleaning (a significant priority identified by the Director of Nursing in the Public Health Agency); a Management Allowance (to recognise the additional complexity of managing Care Homes with Covid-19 measures in place); the costs of time for testing and swabbing for the rolling programme of testing; costs associated with supporting visiting and care partners; clinical waste and laundry costs; and home insurance costs (for which there was evidence of significant increases).

33. I believe this additional funding was instrumental in maintaining the resilience of providers, as well as for protecting the staff and service users within them.

Establishment of General Dental Services support & rebuilding schemes.

34. From 2020 to 2022/23, over £95m was invested in dental services to help support the challenges and recovery of the pandemic. In April 2020 I launched the Coronavirus Financial Support Scheme for General Dental Practitioners [INQ000185434] and

[INQ000185479] which was designed to provide additional support payments to cover their costs during the Coronavirus pandemic, including staff costs. In July 2020 I allocated further funding to allow dental practitioners to purchase level II personal protective equipment [INQ000185438] and [INQ000185480]. In June 2021 I established the General Dental Services (GDS) Rebuilding Stakeholder Group to help address the ongoing and immediate issues facing the service, and to help inform decision-making around the medium- and longer-term issues that the pandemic had created. A £5m Revenue Grant Scheme was launched on 27 January 2022 by the Health and Social Care Board (HSCB) for dental practices to support the cost of improving and increasing their delivery of General Dental Services. The introduction of the Rebuilding Support Scheme (RSS) in April 2022, along with an easing of infection prevention control measures, was shown to be effective in increasing capacity within dental practices, resulting in improved access for patients [INQ000185439] and [INQ000185481].

Support for General Practitioner services

35. Since the start of the pandemic the impact of COVID-19 on primary care has been significant. For many people, primary care was the first point of advice and support, and to this day, the pandemic is having an impact on the staff who work in this sector. COVID-19 presented major challenges for GP services' normal ways of working and accelerated the shift towards virtual consultations. During my tenure as the Minister for Health I allocated funding to allow GP practices to invest in new telephony services and to provide additional consultative sessions.

Support for Hospices

36. I was mindful of the challenges the pandemic was placing on Northern Ireland's hospice service. That is why in January 2021 I allocated an additional £1.754 million to allow the hospice service to respond to increased costs of personal protective equipment, deep cleaning, the purchase of additional video and IT equipment and to support a move to more services being provided in people's homes [INQ000188805] and [INQ000185483]. In March 2021, I allocated a further £1.3million to support NI hospices [INQ000185440] and [INQ000185484].

Support Funds

37. I made several Ministerial directions to Department of Health officials to establish funds in key health sectors in Northern Ireland. On 22 March 2021 I issued a Ministerial direction to establish a fund to meet high level outcomes to support carers

in undertaking their caring role, to the value of £4.4m. The Carers Support Fund provided support for organisations working for and with carers. The funding provided improved access to and availability of advice services for carers, enhanced provision of and access to practical supports, the provision of a listening ear service, increased short-break capacity and self-advocacy training [INQ000185444].

38. On 31 March 2021 I also wrote to the Executive and circulated a paper detailing my proposal to establish a £10m Cancer Services Support fund [INQ000185445] and [INQ000185485] which was to support cancer charities in undertaking their role in supporting HSC services. I also proposed establishing a £10m fund to support mental health charities [INQ000185446], a one-off award of £15m to HSC Charitable trust funds and £1.3m support for NI hospices [INQ000185447] and [INQ000185486] (as noted above). Their approval was sought and subsequently provided on the same date.

Establishment of Northern Ireland modelling group.

39. Early in the pandemic a Northern Ireland COVID-19 modelling group was established to review and monitor the trajectory of the virus [INQ000185453]. The group comprised of academics as well as public health experts. Each week the group considered the emerging evidence and latest data on the number of COVID-19 tests, cases, hospital admissions, and deaths and agreed a range for the reproduction number 'R'. This analysis was central to my deliberation of key decisions, recommendations and as well as informing the wider public health response by the Northern Ireland Executive. Importantly it was also central to service planning decisions right across the Health and Social Care sector. I found it beneficial within the Department of Health to be able to regularly receive reliable and expert advice on the wide of disciplines. Throughout the duration of the pandemic, I found the assistance of the Chief Medical Officer and Chief Scientific Officer particularly valuable, it was also beneficial that they attended meetings of the Northern Ireland Executive and were regularly called upon by a range of Ministers to provide professional advice and assessment.

Prioritisation of testing and vaccination for elderly & care home residents.

40. Protecting the elderly, and residents and staff in our care homes was a key priority throughout all phases of the COVID-19 pandemic. In the earliest stages of the pandemic, testing was reserved for the highest priority areas, including the most ill

and vulnerable patients in hospitals, care home settings and for health and care workers. It was immediately recognised, however, that in recognition of Care Homes being distinct from other care settings, as well as having a different risk profile, that the sector required comprehensive support and prioritisation. On 18 May 2020, I announced that the testing programme was to be extended with testing made available to all Care Home residents and staff across Northern Ireland [INQ000185454]. This included testing in Care Homes which had not previously experienced a COVID-19 outbreak. By 30 June 2020, staff and residents in all care homes across Northern Ireland had been offered COVID-19 testing. 41. When it came to vaccination, as Minister I was closely guided by the Joint Committee on Vaccination and Immunisation (JCVI). It identified Care Home residents as *a* top priority group; however, in Northern Ireland we took the position that they were to be *the* top priority. I remain proud that the very first day of the Northern Ireland vaccination programme included the vaccination of the residents of a Care Home. I believe the Northern Ireland specific approach to testing and vaccination undoubtedly reduced the impact of COVID-19 on Care Home residents and staff throughout the course of this pandemic.

Strategic approach to rebuilding

42. The pandemic had a detrimental impact on the delivery a wide range of crucially important health care activities. Whilst this was unavoidable, particularly given the already vulnerable state of the health service pre-covid, I asked Health and Social Care Trusts produce publicly available plans quarterly plans, setting out the commitment to incrementally increase capacity, before resuming normal service provision as quickly as possible [INQ000185455].

Cross Departmental collaboration

43. Whilst at times there were have been tensions across Executive Departments, nonetheless, there were some illustrations of effective cross department/cross body collaboration. For instance, the September 2020 establishment of the Education Support Cell supported schools and other educational establishments to manage confirmed cases of COVID-19 in school settings. The Education Support Cell allowed the Department of Health and the Public Health Agency to work collaboratively with the educational sector. Another example which I was very pleased to see delivered, was the additional swab testing capacity within the Pillar 1 network, being defined as testing through the academic consortium that consisted of local universities as well as the Agri-Food and Biosciences Institute (AFBI) which is sponsored by Department

for Agriculture, Environment and Rural Affairs (DAERA) and local industry partner, Almac.

EU exit planning

44. I also believe Northern Ireland benefitted from the additional emergency planning that had been undertaken earlier for the event of a no deal EU Exit. This resulted in a larger than normal reserve of personal protective equipment being available for deployment in Northern Ireland, as well as the rapid standing up of appropriate cross-departmental and cross-body engagement forums. As stated above in para (24), at the start of the pandemic, the Business Services Organisation was holding an additional six weeks stock, based on 'business as usual' stock levels at the time, of a range of medical devices, clinical and non-clinical consumables as part of action taken against supply chain disruptions related to the impending EU exit. This stock contained aprons, gloves and T11Rs masks. This contingency stock did not include other items of PPE such as FR Gowns, FFP3 Respirators and face shields.

Absence of a power-sharing government in NI

45. In my opinion, the lack of an Executive between 2017 and 2020 had an adverse effect on the preparedness of the health and social care system. It contributed greatly to inadequate staffing levels, across the health service in Northern Ireland; it resulted in key decisions not being taken; it allowed an unsustainable gap to develop between demand and health and social care capacity; and, it saw the loss of strategic political oversight at the top of the Department of Health. The three-year hiatus occurred shortly after the publication of the keynote Bengoa report [INQ000185456] and the Delivering Together report [INQ000185457] on transforming Northern Ireland's health service. These reports were produced against a backdrop of rising demand for health and social care services, and an associated deepening shortfall in actual HSC capacity. As a result, too many people were having to wait too long for treatment and waiting times in Northern Ireland had become by far the worst in any region of the United Kingdom. The recommendations and actions within these reports, which included a renewed focus on reconfiguration, population health and workforce were unable to be developed and progressed in the absence of the local political structures.

46. The absence of a Minister of Health and Executive during that period undoubtedly delayed much-needed progress. The same can be said in relation to the delays caused in the reform of adult social care.

47. The political and Governmental limbo between 2017 and 2020 prevented progress towards a multi-year budget, which in turn inhibited the ability to take any long-term strategic decisions. In addition, when I took office there was ongoing industrial action by healthcare workers which required my immediate attention to rebuild relationships and trust. I would contend that it is entirely possible that if there had been a functioning Executive during the period 2017 and 2020, that the industrial action would have been avoided. Without a functioning Executive, the restoration of pay parity sought by Health workers, could not be delivered by Departmental Officials. Issues relating to pay parity and patient safety sparked the industrial action. The absence of a functioning Executive prolonged the industrial action, which is evident given the swift resolution of the issues, once government in Northern Ireland was restored. However, that loss of confidence from staff, the depletion of staff, as well as the inevitable disruption to the delivery of core health and social care services, inevitably had a negative effect on the resilience of the local health and social care system as it entered the pandemic phase.

48. The reestablishment of the Northern Ireland Executive was predicated on a document which was co-authored by the United Kingdom and Republic of Ireland Governments, entitled "New Decade New Approach" ('NDNA') from January 2020. The 'New Decade New Deal' document was heavily focussed on health, and it was recognised by all parties that substantial interventions and support was needed in the Department of Health.

49. The first priority listed in New Decade New Deal was that of "*transforming our health service (with a long-term funding strategy)*", and I believe that this was an indication and acceptance by all involved that the health service in Northern Ireland had not received the support that it had required in the past.

50. It is important to also say something about 'Four UK Nation' working. Whilst many of the economic support and public health measures adopted throughout the course of the pandemic were similar across the four UK nations, due to the range of devolved powers available to the governments of Scotland, Wales and Northern Ireland, there

were often divergences. Amongst these differences were how and when decisions were taken regarding the implementation and easing of COVID-19 restrictions.

51. Overall, I was satisfied with the level of engagement between the respective Ministers of Health across the devolved administrations and central government. Until October 2022 I was the only UK Health Minister that was still in place from the outset of the pandemic, so I worked with a wide range of Ministerial counterparts. From the onset of the pandemic, I found the regular four UK nations Ministerial meetings particularly useful. These meetings provided a forum for discussions on key points such as, respective observations on disease trajectory and the delivery of treatments and vaccination. Outside of the meetings however there was also engagement as and when necessary. An example of this would be the mutual sharing of items of PPE at start of the pandemic.

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**

Date: 24 May 2023