UK COVID-19 PUBLIC INQUIRY

MODULE 2C – DEPARTMENT OF HEALTH (NI) DRAFT CORPORATE STATEMENT – WAVE 1 (Revised following supplementary questions received 12/01/24)

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Witness Name:
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF Peter May, Permanent Secretary, Department of Health, Northern Ireland

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MODULE 2C – DEPARTMENT OF HEALTH (NI) DRAFT CORPORATE STATEMENT – WAVE 1 Revised

I, Peter May, will say as follows: -

1. On 4 April 2022, I took up post as Permanent Secretary for the Department of Health and Chief Executive of Health and Social Care (HSC). I previously held Permanent Secretary positions in the Department of Justice, Department for Infrastructure and the Department of Culture, Arts and Leisure.

2. My predecessor in the Department of Health was Richard Pengelly who was in post from 2014.

3. Given my recent appointment, I have limited first-hand knowledge of the events and issues set out. In preparing this statement, I have relied on my staff who have carried out a thorough review of the documentary evidence held by the Department. I have also discussed the substance of this statement with senior colleagues, who had first-hand experience of the matters described.

4. It is important to emphasise that NI's response to the Covid-19 pandemic was made possible by incredible resilience and commitment.

5. The pandemic stretched and challenged society as a whole as never before. Citizens across the province made incalculable sacrifices to help protect those most vulnerable to the virus.

6. NI's entire health and social care system, including those working in the Department of Health, bore a heavy burden in trying to keep people safe throughout this time and worked tirelessly to that end. There is much that was done that we believe was of great benefit to society, but alongside that we recognise there will always be lessons to be learned from something of this scale and impact.

7. Sadly, Covid-19 did claim lives on a significant scale. Those we lost and those who are still grieving for them must be uppermost in all our minds as we review the response to the pandemic.

STATEMENT PART 1: INTRODUCTION

8. On Friday 24 January 2020 Robin Swann MLA, Minister of Health (the "Minister") made an urgent Written Statement ("statement") to the Northern Ireland Assembly ("the Assembly") [PM/1 - INQ000103599 (DoH ref: PM0001)] to update Members of the Legislative Assembly ("MLAs") on the global impact of Coronavirus (hereinafter referred to as "Covid-19", "Coronavirus" or "the virus)", and the response to date. The Minister also informed the Assembly of the range of measures that the Department of Health (Northern Ireland), (the "Department") and the Public Health Agency (Northern Ireland), ("the PHA"), had initiated to protect the health of the people of Northern Ireland ("NI").

In his statement the Minister said:

> *"I can inform members that my department along with the PHA are in contact with the relevant authorities across the UK to ensure that we have a fully coordinated and effective response to the management of Coronavirus. I have also been in contact with my fellow Health Ministers to discuss our approach. Moreover, my officials have been in contact with their counterparts in the Republic of Ireland in order to ensure that there is appropriate coordination and cooperation between the two jurisdictions.*

The PHA are working with the HSCB primary care and Trusts to ensure the appropriate testing, clinical pathways and communication lines are in place for dealing with any suspected cases in Northern Ireland. We will continue to ensure they have access to the most up to date scientific and medical evidence and guidance on these issues. I will be liaising with Executive colleagues to ensure advice is provided to other organisations as is required".

9. The Minister's statement, made at the start of the outbreak, established the approach of strategic partnership, which was taken by the Department, throughout the pandemic. This strategic partnership approach was designed so that the Department could work collaboratively across government, at regional, national and international levels, and with the NI Health and Social Care (HSC) sector, to ensure a fully coordinated and effective response to the management of Covid-19 within NI and its neighbouring UK and Republic of Ireland jurisdictions. The Minister ended his first statement to the Assembly in respect of the outbreak, by stating that "*my priority as Minister is to ensure effective measures are in place within Northern Ireland, and that our communications with the people are informed*".

SECTION A: DEPARTMENT OF HEALTH – ROLE, FUNCTIONS, RESPONSIBILITIES, STRUCTURE, LEADERSHIP AND FUNDING

10. The Department of Health ("the Department") is one of nine departments which comprise the Northern Ireland Executive. The Department's role, functions, and responsibilities both prior to and during the pandemic fundamentally remained the same. The Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 are to promote an integrated system of health and social care (HSC) designed to secure improvement in: the physical and mental health of people in Northern Ireland; the prevention, diagnosis and treatment of illness; the social wellbeing of people in Northern Ireland.

11. The Department discharges these responsibilities, both by direct Departmental action and through its Arm's Length Bodies (ALBs), by developing appropriate policies; determining priorities; securing and allocating resources; setting standards and guidelines; securing the commissioning of relevant programmes and initiatives; monitoring and holding to account its ALBs; and promoting a whole system approach.

12. There were 17 ALBs during the pandemic, reduced to 16 following the dissolution of the Health and Social Care Board (HSCB) in March 2022.

13. Prior to April 2022 the Department's principal service delivery objectives for HSC commissioners and HSC Trusts were set out in detail in the annual Health and Social Care Commissioning Plan Direction. The annual Health and Social Care Commissioning Plan Direction was issued by the Department to the Health and Social Care Board (HSCB), the ALB responsible for the commissioning of health and social care services in NI. Following the dissolution of the Health and Social Care Board in March 2022, its functions were, in the main, transferred to the Department except for Social Care and Children's functions, and its staff were transferred to the HSC Business Services Organisation (BSO). Responsibility for Social Care and Children's functions was placed directly upon Health and Social Care trusts. The Health and Social Care Act (Northern Ireland) 2022 inserted a new Article 10A of the Health and Personal Social Services (Northern Ireland) Order 1991 which provides a definition of Social Care and Children's functions and the Department has responsibility for the oversight of the exercise of these functions. The dissolution of the Health and Social Care Board meant that there was no longer any requirement for the Department to issue an annual Health and Social Care Commissioning Plan Direction.

14. In October 2020, the Minister approved a programme of work on the development of an Integrated Care System (ICS) model in NI. The model will aim to promote and enable integration and partnership working across the HSC, and with external partners, to deliver services [PM/2 - INQ000114846 (DoH ref: PM0002)].

Emergency Response Role

15. In February 2009, in line with the Cabinet Office's best practice guidance, defined the Department's Lead Government Department role [PM/3 - INQ000145671 (DoH ref: PM0152)], updated in August 2012 [PM/4 - INQ000188749 (DoH ref: PM5010)] for responding to the health consequences of emergencies arising from chemical, biological, radiological and nuclear incidents; disruptions to the medical supply chain; human infectious diseases; and mass casualties.

16. The health response from the Department, for which it has been designated Lead Government Department, is dictated by the severity and complexity of an emergency. The severity and complexity of the emergency will also dictate whether activation of Health Gold Command is required. The structures, systems and processes involved in responding to an emergency are defined within the Emergency Response Plan 2019, which is currently under review. The Emergency Response Plan 2019 was activated in January 2020 in response to the emergence of the SARS-CoV-2 virus which is responsible for the disease that became known as Covid-19.

17. The Civil Contingencies Framework for NI (2011) [PM/5 - INQ000103600 (DoH ref: PM0003)], published by the Executive Office (NI), also required the Department to maintain, review and update its Emergency Response Plan [PM/6 - INQ000184662 (DoH ref: PM5013)] and to test and exercise the plan response arrangements. The Department will also provide strategic health and social care policy advice and/or direction in support of the efforts of others, including its associated agencies[1] and ALBs in response to emergencies for which it had been designated lead. In such circumstances, the Minister of Health is required to lead, direct and co-ordinate the response for NI, reporting as necessary to the NI Executive under the Northern Ireland Central Crisis Management Arrangements (NICCMA) Protocol [PM/7 - INQ000103601 (DoH ref: PM0005)] when an emergency has been categorised as Serious or Catastrophic and requires a cross-departmental or cross-governmental response.

Northern Ireland Central Crisis Management Arrangements (NICCMA)

18. When an emergency occurs which is likely to have a serious impact on all or part of Northern Ireland, central crisis management arrangements can be activated to enable a clear understanding that organisations within the framework have moved from PREPARE to RESPONSE mode. The Northern Ireland Central Crisis

[1]Health and Social Care Board (dissolved April 2022) Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency; Northern Ireland Guardian ad Litem Agency, Northern Ireland Social Care Council, Northern Ireland Fire and Rescue Service (NIFRS); Northern Ireland Practice and Education Council; Public Health Agency (PHA); Business Services Organisation (BUSINESS SERVICES ORGANISATION); Patient and Client Council (PCC); Northern Ireland Ambulance Service (NIAS); Western Health and Social Care Trust (WHSCT); South Eastern Health and Social Care Trust (SEHSCT); Belfast Health and Social Care Trust (BHSCT); Southern Health and Social Care Trust (SHSCT); Northern Health and Social Care Trust (NHSCT); Regulation and Quality Improvement Authority (RQIA)

Management Arrangements or 'NICCMA' states that "when a major emergency has occurred or is anticipated which is likely to have a serious impact either locally or regionally in Northern Ireland, central strategic co-ordination arrangements can be activated as required to co-ordinate the response both within and outside of Northern Ireland.' NICCMA Protocol 2016 [PM/8 - INQ000188741 (DoH ref: PM/5003)].

19. The Civil Contingencies Group (Northern Ireland) (CCG (NI)), is the principal strategic civil contingencies preparedness body for the public sector. At the time of Covid-19, CCG (NI) was chaired by the Head of Civil Service (HOCS) and membership comprised representation from all NI government Departments as well as local government, the Food Standards Agency, the emergency services and the Met Office. CCG(NI) is responsible for providing strategic leadership to civil contingencies preparedness by agreeing policy and strategy on cross cutting issues. CCG(NI) has oversight and responsibility for pandemic planning in non-health areas in NI including sector resilience.

20. CCG (NI) is also the key information sharing body that participates in the effective delivery of the Central Crisis Management Arrangements in Northern Ireland as may be necessary during an emergency. Until January 2023 the Department's representative on CCG (NI) was the Director of Population Health and/or the Deputy Chief Medical Officer for Public Health. Since January 2023 the Department's representative on CCG (NI) has been the Director of the newly established Directorate within the Department now referred to as the Emergency Preparedness, Resilience and Response Directorate.

21. The protocol and framework set the governance arrangements for managing the NI Executive's response to the pandemic at the start of the outbreak when notified by the World Health Organisation on 31 December 2019. Paragraphs 77 to 134 below set out the length of time which elapsed between the emergence of the virus and the steps taken in NI by the Department to respond to it as a public health emergency. During the period 31 December 2019 to 9 March 2020, the Department acted in accordance with the requirements of these governance documents, informed by the UK public health impact assessment, which was provided within the extant information sharing arrangements for the UK four nations (see paragraphs 163 to 165 below). The Department had no evidential basis for concluding that it required the ability to act differently from the requirements set out in the governance documents or the arrangements for the UK four nations information sharing, related

to national and international threats to public health. The Department also had no evidential basis to conclude that an enhancement of the NI scientific expertise available to it was required in order to pre-empt the action taken by the UK Government in terms of steps taken to contain the virus across the UK. However, this situation was monitored closely and, in response to the evolving pandemic, the CMO agreed a proposal by the Chief Scientific Adviser to establish a NI Group, for the purpose of specifically focusing on scientific evidence (see paragraphs 145 to 147 below).

22. The Executive Office (TEO) has responsibility for leading civil contingencies preparedness and response, as well as non-health pandemic planning and wider consequence management in Northern Ireland. The CCG (NI) has oversight and responsibility for pandemic planning in non-health areas and for overseeing delivery of a cross-cutting work programme to enhance resilience in NI. The Department is responsible for managing the health consequences of emergencies as described in the Department's Lead Government Department Plan and in the Department's Emergency Response Plan.

23. In March 2018, the Department, in collaboration with the Department of Justice and The Executive Office, formally established a Civil Contingencies Group NI pandemic flu Northern Ireland sub-group to engage as part of the UK-wide Pandemic Flu Readiness Board (PFRB). The NI sub-group was placed under the auspices of the Civil Contingencies Group NI via the Resilience Programme. The draft Bill would provide a menu of options to be used in an emergency situation. These were intended to be measured and proportionate and to protect society as a whole.

24. NI specific options included in the draft UK Pandemic Flu Bill were aimed at enhancing the powers contained within the primary legislation pertaining to public health in NI, the Public Health Act (Northern Ireland) 1967. This included the following powers:

- to increase the available health and social care workforce, by allowing recently retired health and social care staff to come back to work in order to support the efforts to tackle this outbreak;

- to ease the burden on frontline staff, by reducing the number of administrative tasks they have to perform, and allowing key workers to perform more tasks remotely and with less paperwork;
- to contain and slow the virus by reducing unnecessary social contacts, for example, through banning certain mass gatherings and controlling school and childcare closures;
- to manage the deceased with respect and dignity, by enabling the death management system to deal with increased demand for its services; and
- to support people by allowing them to claim Statutory Sick Pay from day one, as well as by helping the food industry to maintain supplies.

25. This work proved critical during the emergence of SARS-CoV-2 as the draft Bill was the prelude to the Coronavirus Act 2020 (see paragraphs 50 to 60 below). Receiving Royal Assent in March 2020, the Coronavirus Act 2020 contained legislative measures to provide the Department and other Executive departments in NI with the necessary emergency powers to act in a rapid and effective way to deal with the evolving and severe pandemic. At this time, the Department also took into consideration measures in the draft Pandemic Flu Bill to address gaps in the Public Health Act (Northern Ireland) 1967 that would be relevant in the event of an influenza pandemic affecting NI.

26. Subsequent to the Coronavirus Act 2020 receiving Royal Assent, the NI Assembly passed on 28 March 2020, The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 which made provisions to enable a number of public health measures to be taken to reduce the public health risks posed by the spread of Covid-19.

27. The introduction of the first "lockdown" in NI was earlier in the first wave, compared to some other parts of the UK. At the start of the pandemic it was not known how long it would take for specific medical countermeasures to be introduced, such as vaccines and new drug treatment. Neither was it known how long NPIs would have to used, if implemented, or to what extent the consent of the population could be secured for their use, given their damaging consequences. Each of the measures differed in their effectiveness, degree of difficulty, evidence base, and negative wider health, social and economic consequences. At all times, the scientific

and medical advice, and the decisions of Ministers and the Executive, had to recognise the harms caused by these measures. The time of required to implement these measures also had to be considered. Any such decisions to move ahead of the rest of the UK had to be considered and agreed by the Executive in advance of legislation, given the cross-cutting nature of the impacts.

28. The population was asked to make profound changes, and the Department recognised that the effectiveness of this approach depended largely on the extent to which individuals were prepared to adhere to NPIs in a consistent manner. It was recognised that it was important for there to be a consistent approach in relation to the messaging about what had to be done, as well as providing information about practical support for activities of daily life, including financial support, such as the furlough scheme and statutory sick pay.

29. Health Gold Command consisted of two key elements: the Strategic Cell and the Emergency Operations Centre (EOC). The Strategic Cell provided strategic health and social care policy advice to the Minister. It also provided health, social care and public safety advice, direction and leadership to HSC organisations and to other departments/organisations. The second element, being that of the Emergency Operations Centre, was responsible for management of the flow of information into and out of the Strategic Cell between the Department and HSC sector, and the wider NI Executive departments and UK Government. Activation of the Emergency Operations Centre is not reliant on the full activation of both key elements of the health Gold Command structure and can operate without activation of the Strategic Cell. However, the Strategic Cell requires the support of the Emergency Operations Centre to function.

Shared Responsibilities with other NI Departments

30. The Department also works in partnership with other NI Executive departments to develop and implement cross-cutting policy which is designed to improve the health and wellbeing of the population and in areas such as suicide prevention, tackling homelessness, the safeguarding of vulnerable adults and children, and suicide prevention.

Structure and Senior Leadership

31. The diagram provided at [PM/9 - INQ000137413 (DoH ref: PM0240)] sets out the Department's organisational structure at policy group level, its senior leaders, and their respective group areas of responsibility as at 1 January 2020. The senior officials and professional officers identified in the diagram comprise the Department's Top Management Group and the Departmental Board. The Top Management Group and the Departmental Board have responsibility for the overall corporate governance of the Department and ensuring that the Minister's policies and priorities are implemented in compliance with all statutory, regulatory and financial management requirements to which NI Executive departments adhere. Both the Top Management Group and the Departmental Board are chaired by the Department's Permanent Secretary who is the Department's Accounting Officer. The Permanent Secretary is also the overall Chief Executive and Accounting Officer for the statutory-based health and social care bodies in NI reporting to the Minister. [PM/10 - INQ000137414 (DoH ref: PM0241)] provides the Top Management Group's respective roles and responsibilities both before and during the pandemic.

32. The Top Management Group has regular weekly meetings. The Departmental Board, which also has two Non-Executive Directors among its membership, meets every two months. The Top Management Group is the main vehicle for managing the Department on a day-to-day basis whereas the Departmental Board has oversight for monitoring the effective discharge of corporate governance. Whilst not formally stood down during the pandemic, the frequency of Departmental Board meetings was reduced. This meant that only two meetings were held in 2020 and three meetings were held in 2021.This reduction in meetings was to permit the Department to focus on the additional workload arising from the pandemic. The Top Management Group weekly meetings were also paused from 19 March 2020 to 18 May 2020 as the Department's senior team were fully engaged in leading the emergency response.

33. The Transformation Implementation Group was established in November 2016 and chaired by the Department's Permanent Secretary. The purpose of the Transformation Implementation Group was to provide the strategic leadership to oversee and make decisions on the design, development and implementation of the Delivering Together Transformation Programme published by the Department on 25 October 2016 [PM/11 - INQ000353594 (DoH ref: PM0352]. The membership of the

Transformation Implementation Group encompassed the Department's Top Management Group and the HSC executive and clinical leaders drawn from the Department's Arm's Length Bodies (see paragraph 17 above). The work of the Group was temporarily suspended at the start of the pandemic as the Department's main objectives were to manage the HSC response to the emergency, and in summer 2020, to commence the process of rebuilding service delivery (see paragraphs 609 to 619 and paragraph 620 below). The HSC Rebuilding Management Board (see paragraph 615) replaced the Transformation Implementation Group from summer 2020.

34. The Transformation Advisory Board was established in December 2016 to oversee the direction of reform in health and social care. The Transformation Advisory Board was chaired by the Minister, and its membership was drawn from the field of independent healthcare experts, trade unions, service users and community and voluntary sector representatives. The work of the Board was temporarily suspended at the start of the pandemic as the Department's main objectives were to manage the HSC response to the emergency and in summer 2020 to commence the process of rebuilding service delivery (see paragraphs 609 to 619 below). The Transformation Advisory Board was re-established in December 2020, although it did not have a role in relation to the Department's response to the pandemic.

General Funding

35. The general means of funding provided to the Department is through the Department of Finance in Northern Ireland. The Department is provided with an opening budget and any easements are declared or additional funding requirements are bid for through "Monitoring Rounds" in-year (June, October and January). Transfers of funding both between other NI departments and from other UK departments (via HM Treasury) are also processed through the Department of Finance at a Monitoring Round.

36. The pandemic covered a number of financial years, and the impact of the pandemic is still ongoing. Covid-19 commenced in the 2019/20 financial year, and the main impact of Covid-19 was within the 2020/21 and 2021/22 financial years. There are still significant Covid related costs being incurred in 2022/23.

37. During this period, additional funding exercises were commissioned by the Department of Finance to determine requirements and redistribute ring fenced Covid-19 funding in addition to and/or alongside Monitoring Rounds. The Department also received a Budget Cover Transfer (BCT) directly from the Department of Health and Social Care for Covid-19 Testing during the pandemic. This Budget Cover Transfer supplemented the general funding arrangements underpinning the National Testing Programme across the four UK nations whereby, in summary, Northern Ireland and the other Devolved Administrations received a Barnett (population-based) share of National Testing Programme capacity in lieu of the consequential funding they would otherwise have received from health spending in England. Outputs funded under the National Testing Programme, managed centrally by Department of Health and Social Care, included for example delivery of the public facing COVID-19 PCR testing sites and the supporting laboratory processing capacity, and procurement of new COVID-19 test technologies (for example Lateral Flow Devices).

38. While Covid-19 commenced in 2019/20 and some Covid-19 related costs materialised in that year, these costs were contained within existing budgets. In 2020/21 the Department received £989m of additional resource Covid-19 Funding. However, final spending on Covid-19 exceeded this budget by £11.1m, with the overspend authorised by the Department of Finance. In 2021/22 the Department received £610m of additional resource Covid-19 Funding, including a Budget Cover Transfer of £49m in relation to Covid-19 Testing, and the underspend against this was £3.3m. Resource spending included: support for the health and social care workforce, including a one-off acknowledgement payment for service during the pandemic; support for additional service delivery, including testing and contact tracing; support for independent providers of health and social care; purchase and consumption of PPE; revenue costs associated with capital works; and additional support costs including increased cleaning.

39. Capital funding of £70m was provided in 2020/21, with an underspend of £2.4m declared at year end. In 2021/22 the Department received an additional £15.7m of capital in relation to Covid-19, reporting an underspend of £1.5m at year end. Capital spending included purchase of medical equipment including oxygen generators, capital works to provide necessary adaptations to facilities, ICT to support homeworking and other IT infrastructure developed as part of the Covid-19 response, such as the Track, Trace & Protect Contact Management System. No resource funding requests made by DoH during the pandemic were refused however

a bid for Capital funding was refused by the Department of Finance in September 2020. The Department of Finance referenced the Department's capital underspend in the previous year and advised the capital bids would be considered pending an assessment of the Department's capital spending plans against the capital budget allocation for that year. A paper was provided to the Department of Finance and the funding was subsequently allocated in the October 2020 Monitoring Round.

40. Funding for individual initiatives was considered in line with the guidance issued by the command and control structures and later the Covid-19 Finance Process and Approvals Guidance [PM/12 - INQ000130406 (DoH ref: PM0296)]. To the best of the Department's knowledge, finance did not have an impact on the decision making process during the period covered by this statement (11 January 2020 to 18 March 2022), as the overarching assumption was that the funding required for the necessary response would be made available. However, the availability of surplus funding at the end of 2020/21 did lead to additional responses to the pandemic that may not otherwise have been undertaken.

41. Capital funding of £70 million was provided in 2020/21, with an underspend of £2.43 million declared at year end. This underspend relates to £1.65 million being held as unallocated Covid capital funds at end year with a further underspend of £782,000 reported by Health organisations in their final end year spend returns. The underspend relates primarily to equipment, IT and capital works.

42. In 2021/22 the Department received an additional £15.7 million of capital in relation to Covid-19, reporting an underspend of £1.5 million at year end. This underspend, relating to capital works schemes and IT related schemes, was £370,000 being held as unallocated funds at year end with a further £1.1 million reported by Health organisations in their final year spend returns. Capital spending included purchase of medical equipment including oxygen generators, capital works to provide necessary adaptations to facilities, ICT to support homeworking and other IT infrastructure developed as part of the Covid-19 response, such as the Track, Trace & Protect Contact Management System. No resource funding requests made by the Department during the pandemic were refused, but a bid for Capital funding was rejected by the Department of Finance in September 2020 [PM/13 - INQ000353595 (DoH ref: PM0353]. The Department of Finance referenced the Department's capital underspend in the previous year, and advised the capital bids would be considered pending an assessment of the Department's capital spending

plans against the capital budget allocation for that year. A paper was provided to the Department of Finance and the funding was subsequently allocated in the October 2020 Monitoring Round.

43. Funding for individual initiatives was considered in line with the guidance issued by the command-and-control structures and later the Covid-19 Finance Process and Approvals Guidance issued by the Department [PM/12 - INQ000130406 (DoH ref: PM0296)]. Early in the pandemic the Department of Health was given assurances, both written [PM/14 - INQ000353596 (DoH ref: PM0354] and oral, by the Department of Finance that its Covid-19 funding needs would be met.

44. This assurance was passed on to Health and Social Care organisations and in 2020/21 funding was then provided in accordance with applications made via Covid-19 funding templates. In 2021/22 the process returned to the normal allocation process whereby appropriate funding needs for the Health and Social Care Trusts were assessed by the Health and Social Care Board and notified to the Department. Also in line with normal processes, the needs of other Arm's Length Bodies (which were comparatively minimal) were advised directly to the Department. In both years all funding needs were met in full. In the 2022/23 financial year no additional funding was provided to the Department specifically for Covid-19. However, Health and Social Care organisations were again assured that their Covid-19 funding needs would be prioritised and all requirements (again assessed via the former Health and Social Care Board in the case of the Health and Social Care Trusts) were fully met in the period covered by this statement (Q1 of 2022/23).

SECTION B: THE ROLE OF THE DEPARTMENT IN RELATION TO DECISIONS TAKEN BY THE NI EXECUTIVE DURING THE PANDEMIC

45. Paragraph 2.4 of the NI Ministerial Code [PM/15 - INQ000103602 (DoH ref: PM0006)] requires Departmental Ministers to bring to the Executive matters deemed to be cross-cutting, significant or controversial. Having regard to this requirement, the Department through the Chief Medical Officer ('CMO') and Chief Scientific Advisor ('CSA') provided public health and scientific advice to inform the Executive Committee's decisions on a wide range of policy issues, including: the timing of the introduction of non-pharmaceutical interventions (NPIs); the relaxation of NPIs based on the weekly estimates of R; and regular reviews of NI specific modelling. This

advice informed Executive decisions on NPI countermeasures and included information on the trajectory of the pandemic in NI and approaches to contain and mitigate the impact, including relative and cumulative impact based on evidence from the Scientific Advisory Group for Emergencies (SAGE).

The Value of 'R'

46. The basic or effective reproductive number (R) was one of a variety of data sources used as part of epidemiological modelling to support understanding of the pandemic and to assess scenarios based on the potential impact of different interventions. Other important information that was considered alongside the R number included hospital admissions, hospital bed occupancy, demands for respiratory and critical care support, and mortality data.

47. Using the basic or effective reproduction number (R), to understand how an infectious agent may move through a population is challenging with the development of new variants, changing population immunity, and uncertainties about behaviours.

48. The Department is aware that in a hearing before the Assembly's Health Committee (on 15 October 2020), officials from the PHA appeared to suggest that expert modelling had vastly underestimated the number of Covid-19 cases which had eventuated as at that date.

49. The Department is unable to identify any output of the Department's modelling group led by the CSA which suggests that there would be around 300 cases at the end of September 2020 and therefore do not believe that this estimate originated in the Department. While the modelling group were monitoring the epidemic and producing weekly estimates of Rt, there was not any forward modelling of projected case numbers which covered September 2020 and the first half of October 2020, and therefore there was not any underestimate of the number of cases around the beginning of October 2020 on the part of the modelling group. However, Rt was above 1 and rising throughout September 2020 and the implications, including doubling times, would have been discussed at the modelling group in the presence of PHA members. For example, Modelling Group minutes for 30 September 2020 note a doubling time of around 9 days for case numbers (based on a seven day rolling average).

The Coronavirus Act 2020

50. The Coronavirus Act 2020 was passed at pace at the outset of the Covid-19 pandemic. Receiving Royal Assent on 25 March 2020, the Coronavirus Act 2020 provided legislative measures that were reasonable, proportionate and based on the latest scientific evidence, to provide the Department and other Executive departments with the necessary emergency powers to act in a rapid and effective way to deal with the evolving and severe pandemic. The Coronavirus Act 2020 contained emergency provisions that the Department needed to have at its disposal, to deploy, if required. The powers were considered to have been proportionate to the challenges faced in responding to Covid-19 and were only enacted for the duration of the pandemic, after which time the legislation was withdrawn by way of a natural 'sunset' clause at midnight on 24 March 2022. The exceptions to this sunset clause were the provisions contained in Section 48 and Schedule 18 emergency public health powers. In addition, there are a number of permanent provisions within the Act, which are excluded from the automatic sunset at the end of 24 March 2022, and which would require new primary legislation to repeal. Some of these provisions are still necessary to support the recovery from the pandemic.

51. Section 48 of and Schedule 18 to the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 to provide powers for the Department of Health to make regulations in response to the Covid-19 pandemic. Under this primary legislation the Department was alone empowered to make and amend secondary legislation to bring into effect statutory NPIs. However, the responsibility for decisions to introduce statutory NPIs lay with the Executive, as these restrictive measures impacted across the wider society and economy of NI and therefore were significant, controversial and cut across the responsibilities of two or more Ministers. In many cases the impacts of the restrictions fell within the policy remits of other Executive Ministers and examples of this are given below in paragraphs 52 and 54.

52. In terms of domestic restrictions, the Executive took decisions on the introduction of new restrictions or relaxations of existing ones throughout the pandemic response. Initially the Department developed the Executive papers in respect of which decisions had been taken, and those proposed with input from other departments regarding the social and economic impacts of those restrictions and their practical application. However, in 2021 and the latter period of regulations, The Executive Office (TEO) took the lead in developing Executive papers on the

introduction of new restrictions or relaxation of existing restrictions and sought the Department's input from the CMO and the CSA.

53. In practice, the decision making process involved the Executive agreeing which measures were to be included in regulations, along with the relevant timings of same. Thereafter the Department worked with Departmental Solicitors, and with other Executive departments where appropriate, to draft and make regulations to implement the Executive's decisions, using the power conferred solely on the Department by the Coronavirus Act as mentioned above. The regulations as made, were laid without the need for the Executive to approve a draft.

54. In some instances, the Minister made decisions on technical details that arose in the drafting of the Regulations, informed by advice from officials on the practical out working of Executive decisions and how these could be technically translated into workable legal text. In these cases, the Minister wrote to Executive colleagues to advise them of the decision(s) taken. Technical decisions included, for example, amendments to correct a figure in the regulations, or an anomaly or inconsistency between provisions.

55. Due to the nature of the pandemic and the urgency in which the regulations had to be made, scrutiny of the regulations by the Assembly's Health Committee and debate by the Assembly often took place after the regulations were made.
The restriction regulations were made under the Confirmatory procedure before the Assembly. The scrutiny procedure used in this case was based on the urgency of the need to implement measures, or remove measures if they were deemed to be no longer needed, before it was possible to progress them through the Assembly Committee and Assembly debate stages in the usual way. The emergency procedure is set out in section 25Q of the Public Health Act (Northern Ireland) 1967. Section 25Q was inserted into the Public Health Act by Schedule 18 to the Coronavirus Act 2020.

56. The Health Committee approved each set of regulations to go forward to the Assembly for debate. Officials were present to brief Committee members on the content of the regulations and to answer questions. As part of its deliberations, the Committee had access to a report from The Examiner of Statutory Rules following her scrutiny of the Statutory Rule.

57. The restriction regulations were made under the Confirmatory procedure before the Assembly. The Confirmatory procedure requires regulations to be laid before the Assembly after being made. The regulations would cease to have effect unless approved within a specified period. For example, each set of restriction regulations, as made, under the Public Health Act (Northern Ireland) 1967 required approval by the Assembly before the expiration of 28 days beginning with the day on which they were made.

58. In the Explanatory Note, each set of restriction regulations included the text "No impact assessment has been prepared for these Regulations". During wave 1, the accompanying Explanatory Memoranda outlined that the public health restrictions and requirements introduced by the principal Regulations were part of a range of measures designed to assist and support efforts to protect the population of Northern Ireland by seeking to limit the spread of coronavirus disease. It was further stated that, given the rapidly evolving global situation regarding the spread of coronavirus disease, there had been no assessment of equality, regulatory, or financial impacts in relation to the Statutory Rules.

59. However, a public sector equalities duty impact assessment was completed by the UK Government in respect of the Coronavirus Act 2020, which included clauses pertaining to Northern Ireland [Exhibit PM/430 INQ000411090 (DoH Ref: PM0450)]. Furthermore, the Department did undertake equality and human rights assessments on the principal regulations during 2020 and 2021 and these assessments were published on the Department's website [Exhibit PM/431: INQ000411091 (DoH Ref: PM0451), Exhibit PM/432: INQ000411092 (DoH Ref: PM0452), Exhibit PM/433: INQ000411093 (DoH Ref: PM0453 Exhibit PM/434: INQ000411094 (DoH Ref: PM0454), Exhibit PM/435: INQ000411095 (DoH Ref: PM0455) Exhibit PM/436: INQ000411096 (DoH Ref: PM0456), Exhibit PM/437: INQ000411097 (DoH Ref: PM0457)].

60. Papers submitted to the Executive by the Department which proposed the introduction or removal of restrictions often contained inputs from a number of other Executive departments regarding the social and economic impacts of those restrictions and their practical application. This was also the case for the regular reviews of the regulations, prepared for the Executive by the Department. The review papers presented an update on the trajectory and impact of the pandemic and the measures in place to control the spread of infection. Information on the wider

health, societal and economic impacts of the regulations was also provided and was integral to the consideration of the continuing necessity and proportionality of the measures in place.

61. The Department commissioned the Institute of Public Health in Ireland (IPHI) to provide regular updates on the potential impact of the pandemic and restrictions on Making Life Better indicators (the Northern Ireland Executive's Public Health policy) and these were also used to inform papers submitted to the Executive by the Department on the impact of the pandemic and related restrictions. While under the terms of the subsequent Memorandum of Understanding between NI and the Republic of Ireland in respect of all island cooperation in response to the Covid-19 it was envisaged that consideration would be given to commissioning the IPHI Health to conduct practical research in the context of strengthening the Covid-19 response this did not occur due to many other competing priorities and capacity constraints.

62. A key decision which the Executive had to make at the start of the emergency concerned the timing of the closure of schools to help delay the progression of the virus in NI (see paragraphs 189 to 196 below). Following the review of evidential material and regular consultation and discussions on a UK four nations basis, the Department also submitted aspects of border health policy, which related to the International Travel Regulations to the Executive for decision and agreement. For example, the Department asked for the Executive's agreement on: the need for International Travel Regulations to be created, reviewed and maintained; an agreement to implement a system of pre-departure and post-arrival testing for all international arrivals to NI; the need for the completion of a passenger locator form; and the enforcement of these measures. There was also a requirement for testing and/ or self-isolation for people entering NI and this too was a matter which the Department referred to the Executive for guidance.

63. The Department's Covid-19 vaccination strategy, including prioritisation, was based on advice provided by the UK Joint Committee on Vaccinations and Immunisation ('JCVI') which was approved by the Minister and supported by the NI Executive. The Department's policies on Testing and Contact Tracing; were also presented to the Executive to note or as updates. The Department updated the Executive periodically on the implementation of these policies, including their respective operational delivery.

64. The Department also briefed the Executive periodically on other key policy areas. These updates included mitigations, to alleviate the impact of the pandemic on the delivery of health and social care services, and plans developed to rebuild HSC services following the disruption in the delivery of routine service. These briefings and updates are referred to under the appropriate sections set out later in this statement.

65. Papers submitted by the Department to the Executive as updates or where the Executive was asked to note the content, were presented by the Minister and then discussed and considered collectively, with an opportunity to ask and discuss relevant questions, before noting.

66. The first meeting of Civil Contingencies Group NI, CCG(NI), in response to the pandemic was held on 20 February 2020. TEO convened CCG(NI) in order to bring all Departmental Permanent Secretaries together in its role to coordinate the overall response to the pandemic by the NI Executive. At this first meeting the Department's Deputy Chief Medical Officer (DCMO) gave a presentation [PM/24 - INQ000145666 (DoH ref: PM0090)] to CCG(NI) on the Novel Coronavirus and Northern Ireland's Preparedness. Further daily meetings of CCG(NI) were chaired by the Head of the Civil Service (HOCs) and were attended by the Department's Permanent Secretary. TEO activated the NI Hub[2], the operations centre of CCG(NI) on 18 March 2020 and this remained activated until June 2020. The Department embedded liaison officers in the NI Hub to assist in the coordination of quality and timely information to and from the Department's EOC.

67. The Department also commented on the drafts of the Executive's Recovery Plan [PM/25 - INQ000103603 (DoH ref: PM0009)] of 12 May 2020 which had been circulated to Executive departments by The Executive Office during April and May 2020. Departmental emails commenting on the drafts are provided as exhibits [PM/ - INQ000188749 (DoH ref: PM/5010)], [PM/26 - INQ000103606 (DoH ref: PM0011)], [PM/27 - INQ000103607 (DoH ref: PM0012)], [PM/28 - INQ000103609 (DoH ref: PM0013)], [PM/29 - INQ000103610 (DoH ref: PM0014)], [PM/30 - INQ000103613 (DoH ref: PM0015)], [PM/31 - INQ000103614 (DoH ref: PM0016)], [PM/32 - INQ000103619 (DoH ref: PM0017)], [PM/33 - INQ000103620 (DoH ref: PM0018)], [PM/34 - INQ000103621 (DoH ref: PM0019)], [PM/35 - INQ000103623 (DoH ref:

[2] i.e. the departmental operations centre (DOC) was opened and staff took up their assigned roles within the NI Hub.

PM0020)], [PM/36 - INQ000103624 (DoH ref: PM0021)], and [PM/37 - INQ000103625 (DoH ref: PM0022)]. The Department's response to the Plans of 2 March 2021 and 2 August 2021 is provided in the corporate statements covering the second and third waves of the pandemic.

68. In relation to decision-making, both centrally and within the Department, WhatsApp groups were not used by officials to communicate with either the Executive or internally about significant decisions. Communications in relation to the pandemic concerning the Department, the government, scientific and political advisors, civil servants and other individuals were recorded in Content Manager (formerly known as HPRM and TRIM), the Northern Ireland Civil Service Electronic Document and Record Management system, which is routinely used to manage electronic records. The Department's staff use Content Manager to save and store business area documents, emails and records. Once finalised in Content Manager, the electronic document becomes the legal record of the Department.

69. All NICS employees are required to maintain an accurate record of meetings, decisions and policy documents, in whatever format. This obligation includes the retention of notebooks, paper diaries, etc, that represent the sole record of such activity. This is set out in the NICS Records Management Policy [PM/38 - INQ000120702 (DoH ref: PM0023)].

SECTION C: THE ROLE OF THE DEPARTMENT IN RELATION TO THE FUNCTIONS OF OTHER NI DEPARTMENTS DURING THE PANDEMIC

70. As stated at paragraph 51 above the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 to provide powers for the Department of Health to make regulations in response to the Covid-19 pandemic. Although the Department alone was empowered under this legislation to make and amend secondary legislation to bring into effect statutory NPIs, the policy competence and remits for a number of Executive decisions often lay with other Executive Ministers and their departments, due to the impacts of NPIs across a wide range of sectors, society, and the economy. The Department therefore worked with other NI departments on a range of policy areas related to managing the response to the pandemic. For example, the Minister and the Department for Communities and the Minister and Department for the Economy had joint lead policy responsibility for restrictions affecting the hospitality

and retail sectors. The Minister and the Department for Communities led in relation to sports. Other departments also requested an exemption from border health measures for some key workers travelling to NI. For example, the Minister for the Economy requested the Department to grant an exemption from the International Travel Regulations to seasonal agricultural workers travelling into NI.

71. Not all Executive decisions were implemented by way of legislation and the Department's advice would have been a feature of some policy decisions taken by other NI Executive departments. For example, decisions taken by the Minister for Education and their department on the closure of schools were informed by advice provided by the Department over the course of the pandemic.

SECTION D: AREAS IN WHICH THE DEPARTMENT HAD EXCLUSIVE RESPONSIBILTY FOR THE POLICY RESPONSE TO THE PANDEMIC

72. The Department and its HSC ALBs had exclusive responsibility for the policy response to the pandemic in a range of policy areas. This included the development and implementation of mitigations designed to alleviate the impact of the pandemic on the delivery of HSC services, and the planning to rebuild HSC services following the disruption in the delivery of routine services. The key decisions taken by the Department in relation to the policy response in these areas is covered in detail in the first pandemic wave section provided later in this statement.

73. On 9 March 2020 the Department activated Health Gold Command in line with the guidance set out in its Emergency Response Plan 2019 [PM/6 - INQ000184662 (DoH ref: PM5013)] regarding the levels and approvals necessary to stand up. Paragraph 4.3 in the Emergency Response Plan 2019 states: "*Once activated, Health Gold Command will assess the viability of critical health and social care infrastructures, including medical/clinical supply chains, stockpiles and countermeasures, and make strategic policy decisions about service delivery and surge capacity based on recommendations received from HSC Silver. Health Gold Command, in conjunction with the Departmental strategy for HSC Business Continuity Management, will manage any disruption to critical health services and assist the return to normality for the DoH and HSC organisations when pragmatic and safe to do so*". The activation of Health Gold Command therefore resulted in the Department, by necessity and design, becoming directly involved in the HSC sector's response to the pandemic for the duration of the emergency, within the parameters

set out in paragraph 4.3 in the Emergency Response Plan 2019. Due to the long-term nature of the emergency presented by the Covid-19 pandemic, the level of the Department's direct involvement fluctuated in response to service pressures arising from the prevalence of the virus in the population impacting on service delivery.

74. The Department's direct involvement operated on several levels. The Department:

- led the coordination of planning of the HSC response to the pandemic at the regional level. This is covered in the following paragraphs in this statement: paragraph 135 (Covid-19 Emergency Response Strategy and an Actions/Metrics document); paragraphs 254 to 256 (integrated surge planning); paragraphs 259 to 266 (Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020); and paragraphs 368 to 382 (surge plan for social care);

- led the development of policy and guidance related to the work of the various cells operating within the Gold Strategic Cell (see paragraphs 75 to 76);

- monitored the impact of the pandemic on the delivery of HSC services, and when required, initiated counter measures (see paragraphs 78 to 81). The Department, through Gold Command, also managed the response to issues escalated to it by HSC Silver (see paragraphs 82 to 84). For example, the Department made the decision to open urgent dental care centres in the five HSC Trusts on 4 April 2020 to provide additional capacity (see paragraph 301 below).

- coordinated the management and approval of funding allocated to the HSC to combat the pandemic.

- coordinated the regional response to HSC workforce pressures (see paragraphs 331 to 337.

75. The Department's direct involvement in the HSC sector's response to the pandemic was implemented in partnership with a wide range of service providers. This involved officials meeting directly with service providers, including Arm's Length

Bodies, about service pressures. For examples of this partnership approach, see the following paragraphs 257 to 275 (Primary Care); paragraphs 300 to 303 (General Dental Services); paragraphs 369 to 384, and 482 to 489 (Adult Social Care); paragraphs 521 to 544 (Mental Health); and paragraphs 545 to 568 (Family and Children's' Policy). As a consequence of this partnership approach at no time was it determined to be appropriate or necessary to sign the Emergency Power Orders to empower the Department to direct the HSC sector's response. All service providers continued to operate under extant governance and accountability arrangements.

76. The Department also played a significant role in providing public information and communications on the risks to public health presented by Covid-19, the rationale for NPIs and their benefits to the most vulnerable people in the community. This is covered in a section later in this statement encompassing the first pandemic wave. The Department also engaged with a range of stakeholders across civic society, faith leaders and the business sector to ensure that effective measures were in place within NI, and that people were properly informed about the risks to the public arising from the pandemic.

STATEMENT PART 2: THE START OF THE EMERGENCY

Restoration of the NI Executive

77. The restoration of the NI Executive on 11 January 2020 involved the appointment of a new Minister to the Department just before the start of the emergency. This followed a hiatus of three years when the Department had operated without a Minister, due to the collapse of the previous Executive. The Department has not undertaken any analysis or other exercise to determine the impact on our pandemic response caused by the absence of the Executive. While the absence of Ministers did create certain constraints on decision making generally, our assessment at this stage is that it did not have any significant bearing on decision making in the Department during the response to the pandemic, including during the early stages of the emergency, as Ministers had taken up their post and were therefore able to exercise their powers. In the period leading up to the pandemic, the powers of the Department to exercise its functions were set out in Section 3 of

the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018[3], as exercised in line with guidance published by HMG. Once in force, the Act and supporting guidance established the framework for decision making in NI Departments during suspension. There were a range of general consequences for the Department arising from the limitations on powers which could be exercised by the Department and from the fact that there was no Minister in place. The

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[3] Northern Ireland (Executive Formation and Exercise of Functions) Act 2018

3 Exercise of departmental functions during period for Executive formation

(1) The absence of Northern Ireland Ministers does not prevent a senior officer of a Northern Ireland department from exercising a function of the department during the period for forming an Executive if the officer is satisfied that it is in the public interest to exercise the function during that period.

(2) The Secretary of State must publish guidance about the exercise of functions in reliance on subsection (1), including guidance as to the principles to be taken into account in deciding whether or not to exercise a function.

(3) Senior officers of Northern Ireland departments must have regard to that guidance.

(4) The absence of Northern Ireland Ministers is not to be treated as having prevented any senior officer of a Northern Ireland department from exercising functions of the department during the period beginning with 2 March 2017 and ending when this Act is passed.

(5) The fact that a matter connected with the exercise of a function by a Northern Ireland department has not been discussed and agreed by the Executive Committee of the Northern Ireland Assembly is not to be treated as having prevented the exercise of that function as mentioned in subsection (1) or (4).

(6) Subsections (4) and (5) do not apply in relation to the exercise of a function before this Act is passed if—

(a)proceedings begun, but not finally decided, before this Act is passed involve a challenge to the validity of that exercise of the function, and

(b)the application of those subsections would affect the outcome of the proceedings, but nothing in this subsection prevents the re-exercise of the function in the same way in reliance on subsection (1).

(7) Subsections (1) to (6) have effect despite anything in the Northern Ireland Act 1998, the Departments (Northern Ireland) Order 1999 (S.I. 1999/283 (N.I. 1)) or any other enactment or rule of law that would prevent a senior officer of a Northern Ireland department from exercising departmental functions in the absence of Northern Ireland Ministers.

(8) No inference is to be drawn from subsections (1) to (7) as to whether or not a senior officer of a Northern Ireland department would otherwise have been prevented from exercising departmental functions.

(9) Before publishing guidance under subsection (2) the Secretary of State must have regard to any representations made by members of the Northern Ireland Assembly.

(10) In this section—

"enactment" includes any provision of, or of any instrument made under, Northern Ireland legislation (within the meaning given by section 98 of the Northern Ireland Act 1998);

"Northern Ireland Minister" includes the First Minister and the deputy First Minister;

"the period for forming an Executive" has the meaning given by section 1(5);

"senior officer of a Northern Ireland department" has the same meaning as in the Departments (Northern Ireland) Order 1999 (see Article 2(3) of that Order).

consequences included: the limited ability to take decisions; the policy and financial uncertainty and constraints on opportunities to act on cross-cutting[4] issues. Our general assessment at this stage, based on experience, is that there were no longer term consequences for the pandemic response in NI flowing from the period of suspension. Although there has been no formal analysis of this, we have been unable to identify any examples where difficulties flowing from the period of suspension led to challenges in sustaining our response to the pandemic. /

78. However, the onset of the virus in January 2020 quickly impacted on the Department's ability to make further progress with implementing the transformation of acute health services, or securing the required funding from April 2020, as HSC resources were diverted to manage the response to the pandemic and the rebuilding of services.

Response to the Initial Outbreak of Covid-19

79. Between late-January and April 2020 the Department faced a rapidly evolving and uncertain environment as the outbreak of Covid-19 spread rapidly to become a pandemic.

80. On 22 January 2020, the Department's Health Protection Branch sent a submission [PM/39 - INQ000103626 (DoH ref: PM0024)] to the Minister which provided an update on the Novel Coronavirus in China. On 24 January 2020 the Minister sent an Urgent Written Statement [PM/1 - INQ000103599 (DoH ref: PM0001)] to the Assembly on the response to Coronavirus, stating that:

> "*my Department along with the PHA are in contact with the relevant authorities across the UK to ensure that we have a fully coordinated and effective response to the management of Coronavirus. I have also been in contact with my fellow Health Ministers to discuss our approach.*"

81. On 24 January 2020, the Deputy Chief Medical Officer joined a call and was later copied into the readout [PM/40 - INQ000103627 (DoH ref: PM0025)] from a "National Co-ordination Call" chaired by the Department of Health and Social Care (DHSC), on the Wuhan Novel Coronavirus Incident. This was a 4 nations UK call in

relation to the developing situation to ensure awareness of strategic risk and ensure coordinated action. On 27 January 2020, a meeting of this group gave an update on international diagnosed cases and reported an action which required all UK Devolved Authorities to "*send their figures direct to DHSC (copying to Public Health England) by 12 noon daily* [PM/41 - INQ000103628 (DoH ref: PM0026)].

82. The Department's Emergency Operations Centre (EOC) was activated on 27 January 2020. In line with Section 3.4 of the Emergency Response Plan 2019, the activation was approved by the Director of Population Health and the Deputy Chief Medical Officer [PM/42 - INQ000103629 (DoH ref: PM0027)].

83. HSC Silver (Tactical Command) Structures, as outlined in their Joint Response Emergency Plan [PM/43 - INQ000188753 (DoH ref: PM5018)], were implemented by the Public Health Agency, Health and Social Care Board and Business Services Organisation, and were formally stood up on 22 January 2020.

84. At the time the decision to stand up the Emergency Operations Centre was made, the situation in Wuhan was rapidly developing. The Secretary of State for Health and Social Care updated Parliament on 23 January 2020 that the government's response to coronavirus at this time was to take proportionate, precautionary measures, "*such as enhanced monitoring on flights from Wuhan city and guidance issued on all direct flights from China.*" He also noted that "*The public can be assured that the whole of the UK is always well-prepared for these types of outbreaks and will remain vigilant and keep our response under constant review in the light of emerging scientific evidence.*"

85. On the 27 January 2020, the Secretary of State for Health and Social Care made a statement to Parliament confirming that "*From today, we are therefore asking anyone in the UK who has returned from Wuhan in the last 14 days to self-isolate. Stay indoors and avoid contact with other people – and to contact NHS 111. If you are in Northern Ireland, you should phone your GP*".

86. On 30 January 2020 following the recommendations of the Emergency Committee of the World Health Organisation (WHO), the Director General declared that the outbreak constituted a Public Health Emergency of International Concern. During late-January to early-March 2020 while the risk of the outbreak becoming a pandemic was assessed as moderate, based on the advice of the UK Chief Medical

Officers, the Department commenced planning for the anticipated surge in demand for healthcare services arising from the outbreak. Alongside this, the CMO commissioned the Health and Social Care Board (HSCB) and the Public Health Agency to initiate surge planning for the health service in Northern Ireland, see paragraphs 260 to 261 below.

87. The Department laid legislation in the Assembly to amend the Public Health Act (Northern Ireland) 1967 to make Covid-19 a notifiable disease. The Public Health Notifiable Diseases Order (Northern Ireland) 2020 was made on 28 February 2020 and came into operation on 29 February 2020. The primary effect of this was to require medical practitioners to share patient information with the Public Health Agency if they become aware, or had reasonable grounds for suspecting, that a person they are attending had coronavirus disease. This was also intended to remove any uncertainties about the legalities of sharing such information. The Department issued a letter from the CMO to the HSC providing guidance to clinical staff on what to do if they encountered patients with respiratory infections arriving from overseas [PM/44 - INQ000103630 (DoH ref: PM0030)].

88. By 1 March 2020 NI had its first confirmed positive result for Covid-19 in an individual who had recently travelled from an affected area. The World Health Organisation (WHO) declared the outbreak as a pandemic on 11 March 2020 and, sadly, we had our first death from the virus in NI on 19 March 2020. By 30 April 2020, NI had 3,536 confirmed cases of the disease, and there had been a further 9 deaths.

Initial Changes to the Governance, Staffing and Structures of the Department

89. From late-January 2020 the Department and its ALBs began to alter their organisational structures to redeploy staff resources from delivering usual business activities to resourcing the evolving organisational structures designed to manage the HSC emergency response to the outbreak. The initial changes to the Department's structures evolved further during the pandemic to respond to new developments as they emerged. These changes are set out in the later sections of this statement.

90. The Department activated its Business Continuity Plan [PM/45 - INQ000325157 (DoH ref: PM0031)], [PM/46 - INQ000325162 (DoH ref: PM0356)] on 23 March 2020, which sets out the Department's core critical functions that will be

prioritised in the event of a business continuity incident such as the pandemic. It further notes that other critical work identified at the time of the particular incident will be considered alongside these priorities. During the remainder of 2020 into the early months of 2021, due to the pressures on staffing, the Department paused much of its core business to manage the response to the pandemic. In the early stages of the pandemic staff were redeployed away from all but those priorities regarded as critical at that time. As the pandemic progressed priorities were continually reassessed. As an example the attached Departmental Audit and Risk Assurance Committee paper [PM/47 - INQ000360970 (DoH ref: PM0357)] details governance activities that were paused. From April 2020 to March 2022 the Department paused its formal sponsorship activities related to the governance of its 17 ALBs. Staff from across the Department were redeployed into new roles within the Health Gold Command cellular structure and the Emergency Operations Centre.

91. The Department also introduced new ways of working to assist infection control in its office accommodation, including working remotely for the greater number of its staff and conducting meetings via Zoom and Webex. These new ways of working took time to bed-in, which increased the burden experienced by staff during the early months of the pandemic. However, the alterations to working arrangements eventually proved to be effective and are now part of a new hybrid approach to staff working patterns in the Department.

92. The Department activated its Business Continuity Plan (BCP) [PM/45 - INQ000325157 (DoH ref: PM0031)], [PM/46 - INQ000325162 (DoH ref: PM0356)] on 23 March 2020. The purpose of a BCP is to provide guidance to decision makers, in the event of a serious disruption to normal business in the Department. The BCP identified core functions and services, alongside timescales for recovery, and provided a list of those functions considered most crucial. For example, this critical list included support for Ministers and senior officials, and financial monitoring. It was further noted that other critical work identified at the time of the particular incident will be considered alongside these priorities. During the remainder of 2020 into the early months of 2021, due to the pressures on staffing, the Department paused much of its core business to manage the response to the pandemic. While the BCP provided useful guidance to decision makers it was not intended to cover every eventuality,

thus in practice, due to the dynamic nature of the pandemic, the Department was required to continually monitor and assess its capacity and act accordingly.

93. Difficulties in recruiting additional staff, or obtaining staff by redeployment from other NI departments, placed significant constraints on the Department during the pandemic. While the impact of this has not yet been formally assessed, the Department's senior leadership regularly expressed their concerns about the impact of carrying excessive workloads over a prolonged period on the health and wellbeing of the Department's staff to the Northern Ireland Civil Service Human Resources (NICSHR) Group. NICSHR is part of the Department of Finance, which has responsibility for managing the recruitment and deployment of staff for the NI Executive departments. In the Autumn of 2020 the Northern Ireland Civil Service Board, chaired by the Head of the Civil Service, with membership made up of the Permanent Secretaries from each of the Northern Ireland Government Departments, prioritised the filling of Department of Health Covid-related posts but recognised that several key Department of Health staff remained under significant pressure.

94. During the first wave of the pandemic the Department had several unfilled Covid-related posts at Staff Officer and Team Leader (Grade 7 level) which were identified as a necessary resource for the Gold Strategic Cell's subject specific policy cells. Grade 7 is considered by the Department to be a senior staff position. In the mid to later weeks of the first wave, vacancies for Senior Civil Servants (Grade 5) related mainly to policy work for the Covid-19 regulations (Health Protection) and two new Directorates created in Chief Medical Officers Group (Covid-19 Strategy Directorate and the Covid-19 Response Directorate). Staff from across the Department were redeployed into new roles within the Health Gold Command cellular structure and the Emergency Operations Centre. Therefore, the unfilled vacancies were filled by moving staff from the Department's business areas which had been stood down as part of business continuity and/or in the case of the two new Chief Medical Officer Group G5 posts by temporary promotions from within the Department. The Grade 5 post in Health Protection was temporarily filled by a Grade 5 from another Northern Ireland Civil Service department. Additional Grade 7 officials and their teams recently recruited to manage health service transformation projects were immediately redeployed to the policy cells upon their arrival in the Department (see paragraph 102 below). The Chief Dental Officer post was also unfilled due to long term sickness absence and cover for this post was eventually provided an

HSCB dental professional in an Acting Chief Dental Officer capacity (see paragraph 300 below). The Department moved swiftly, where it was able to do so, to fill posts in Covid-19 areas from within its extant staff complement at the expense of pausing its other business activities. Staff in this situation attempted to keep some of the normal business running at the same time as working very long hours to manage Covid-19 related work without additional cover being provided. The results of this are referred to in paragraph 93 above.

95. In April 2021 the Minister of Health took the unusual step of writing to the First and deputy First Minister, copied to his Executive colleagues, highlighting that staff in the Department of Health were beginning to show serious signs of fatigue and stress, with some highly critical senior staff absences [PM/48 - INQ000145663 (DoH ref: PM0032)]. The Minister was extremely concerned about the wellbeing of his staff. Whilst the Department had sought to bring in additional staff resources through loans and transfers from other departments, aside from some isolated cases of relatively short-term help (for which he was grateful), there had been nothing in the way of material long term assistance.

96. In common with other private and public sector employers the initial impact on maintaining business continuity, following the requirement for staff to work from home, presented challenges which were resolved as home working became routine practice over the course of the pandemic. However, these challenges were outweighed by the greater risk to the community arising from unfettered travel and busy workplace environments had these restrictions not been in place.

The Activation of Health Gold Command

97. An extraordinary meeting of the Top Management Group on 4 March 2020 was called by the Chief Medical Officer to discuss setting up the department's Strategic Cell [PM/49 - INQ000346691 (DoH ref: PM0358)]. A note of that meeting [PM/50 - INQ000103631 (DoH ref: PM0033)] which confirmed the Top Management Group's agreement to full activation of the Health Gold Command was circulated the following day, advising that the Strategic Cell had been convened and would have its first meeting on 9 March 2020.

98. On 9 March 2020 the Department activated Health Gold Command in line with the guidance set out in its Emergency Response Plan 2019 [PM/6 - INQ000184662 (DoH ref: PM5013)] regarding the levels and approvals necessary to stand up. Health Gold Command is outlined in paragraph 16 above.

Strategic Cell

99. The terms of reference for the Health Gold Command Strategic Cell are set out in Annex F of the Department's Emergency Response Plan [PM/6 - INQ000184662 (DoH ref: PM5013)] as follows:

> *"To provide strategic direction, advice and leadership to HSC organisations and, where appropriate, to emergency responders, and to provide wider strategic health advice to:*
>
> - *DoH (including Minister and senior officials);*
> - *other Government Departments (Executive or UK departments such as NIO);*
> - *emergency responders;*
> - *UK-wide emergency response structures (including NSC / COBR / NIOBR / CMG / NICCMA); and*
> - *the media and wider public.*
>
> *To provide oversight of surveillance and infectious disease control for the duration of a Health Gold Command level 2 (serious) or level 3 (catastrophic) emergency for which DoH is the Lead Government Department.*
>
> *To assess the viability of critical health and social care infrastructures, including medical /clinical supply chains, stockpiles and countermeasures, and based on recommendations received from HSC Silver, making strategic policy decisions about service delivery and surge capacity.*
>
> *In conjunction with the Departmental strategy for Business Continuity Management, to manage any disruption to critical health services and assist the return to normality for the DoH when pragmatic and safe to do so".*

100. The Strategic Cell met formally for the first time on 9 March 2020 [PM/51 - INQ000103632 (DoH ref: PM0034)] in response to the growing threat to NI from the

virus. It had regular meetings and operated for the first four months of the pandemic during the initial emergency response phase of the pandemic. It held its last meeting on 16 June 2020. The Strategic Cell was chaired by the CMO or a deputy from the Department's Top Management Group. The meetings were conducted on the basis of a set agenda. The membership of the Strategic Cell included Top Management Group senior officials and the Department's professional officers from the medical, nursing and social care disciplines.

101. Alongside the meetings of the Strategic Cell, the Department's Permanent Secretary chaired a regular early-evening teleconference meeting comprised of the Top Management Group senior officials and the Department's professional officers. The chief executives from the HSC Trusts, HSCB, Public Health Agency and the Business Service Organisation also attended. The purpose of this meeting was to supplement the Strategic Cell meetings by providing the chief executives from the HSC organisations with the ability to directly input to information sharing and reflect on the progress of urgent regional operational issues requiring resolution. Issues impacting on HSC Trusts at the regional level, which were likely to have been discussed at the teleconference included, for example, the supply and distribution of PPE, the demand for critical care beds, the downturn of elective care services and workforce pressures.

102. The diagram provided at [PM/52 - INQ000103633 (DoH ref: PM0035)] provides the overall organisational structure for Health Gold Command which was comprised of the Strategic Cell and of 13 subject-specific policy cells. The remit and staffing for each of these policy cells is provided in the document at [PM/53 - INQ000103634 (DoH ref: PM0036)]. These policy cells were mainly chaired by lead officials from the Department's business areas who were also members of the Strategic Cell. Additional Grade 7 officials and their teams recently recruited to manage health service transformation projects were immediately redeployed to the policy cells upon their arrival in the Department. The redeployment of these staff resulted in the Department's acute health services transformation programme being paused from April 2020 to the summer of 2021.

103. Each policy cell was responsible for monitoring and responding to the impact of the pandemic in specified service delivery/policy areas, escalated to Health Gold by Silver. The response involved developing new policies or responses designed to mitigate or address the difficult, novel, and complex issues faced by the HSC, as the

impact of the pandemic began to take hold and became pervasive across the HSC. Policy recommendations and advice prepared by the policy cells for the Minister to approve were cleared by the Strategic Cell. The clearance of policy recommendations was given either verbally at Strategic Cell meetings or via email, which often included a draft Ministerial submission, circulated amongst the Cell's membership in between meetings. The Strategic Cell worked at pace logging its decisions and actions. [PM/54 - INQ000130312 (DoH ref: PM0037)]

104. The Strategic Cell was stood down in June 2020 following the decision taken by the Department to establish the new temporary Management Board for Rebuilding HSC Services. Paragraphs 607 to 615 below provide the background to these decisions. Alongside the embedding of the Management Board, the Department revised the arrangements for managing the Department's response to the surges in demand for HSC services from Covid-19 patients. The new arrangements involved the establishment of an integrated Covid-19 Gold Command Group, which replaced the Strategic Cell, consisting of senior Departmental officials, alongside senior Health and Social Care Board and Public Health Agency officials. The integrated Gold Command Group met for the first time during wave two on 29 October 2020 [PM/55 - INQ000276293 (DoH ref: PM2009)] and held its last meeting on 4 March 2022 [PM/56 - INQ000276294 (DoH ref: PM2010)]. It was chaired by the Department's Permanent Secretary. Paragraphs 11 to 20 in the Department's Wave 2 corporate statement provides the background to the establishment of the Covid-19 integrated Gold Command Group. Over the summer months of 2020 the Department's response to the pandemic was focused on the rebuilding of services, overseen by the Rebuilding Management Board, while the Gold cells responsible for managing the policy response to surges in demand remained in a state of readiness in the event of any further surge during this period.

Emergency Operations Centre

105. The Department received the first Situation Report (SitRep) regarding COVID-19 from the Department of Health and Social Care on 21 January 2020 and began to monitor the situation closely. The Department's Emergency Operations Centre was activated on 27 January 2020 in response to the emerging threat of Covid-19. Information boards were quickly established in the Emergency Operations Centre to aid decision-makers and to assist in managing the flow of information into and out of the Emergency Operations Centre. These information boards were

continuously monitored and maintained throughout the duration of the emergency response phase. In preparation for the UK's departure from the EU, a cohort of staff volunteers had undergone emergency response training and familiarisation sessions within the Emergency Operations Centre during 2019. These officials were redeployed from routine business areas to work in the Emergency Operations Centre.

106. The main responsibility of the Emergency Operations Centre was to coordinate information, in collaboration with policy leads and the wider HSC ALBs, and to provide SitReps on health and social care related matters. This involved receiving and reviewing the daily "HSC Silver SitReps" and, beginning on 20 March 2020, escalating issues to the NI Hub, which is part of Civil Contingencies Group NI, to inform the "NI SitRep".

107. During the initial response to the pandemic, the Emergency Operations Centre established and maintained a reporting rhythm, which included regular meetings to support Health Gold. In addition, the CMO and Deputy CMO attended ad hoc meetings with HSC organisations as necessary.

108. The days and hours of operation changed throughout the period of the Emergency Operations Centre stand-up; at peak times it operated 7 days a week and late into the evenings. As the emergency became less acute hours were reduced, and eventually the Centre did not operate on weekends. The Emergency Operations Centre was stepped back to a soft stand-up on 15 June 2020, which involved de-escalation from full activation commensurate with the level of the emergency, until it was finally stood down on 11 August 2020.

109. A Departmental Covid-19 Operations Centre, which replaced the Emergency Operations Centre, was established within the integrated Gold Command Group's Surge Directorate. The Permanent Secretary's memo of 22 October 2020 [PM/57 - INQ000276292 (DoH ref: PM2008)], referred to in paragraph 11 in the Department's Wave 2 corporate statement, provides additional information about the Departmental Covid-19 Operations Centre. Paragraphs 14 to 19, in the Department's Wave 2 corporate statement, describe the overall organisational structure, including the Surge Directorate, of the integrated Gold Command Group.

Review of the Emergency Operations Centre

110. Following the stand down of the Emergency Operations Centre (EOC), the Emergency Planning Branch established a review team to engage with key stakeholders to examine the effectiveness of the EOC internally as well as how it interfaced with the Northern Ireland Hub and Health Silver. Two separate questionnaires were developed: one online survey for all staff who had completed a shift in the Emergency Operation Centre [PM/58 INQ000353603 (DoH ref: PM0425)] and one questionnaire which was sent to key staff who had interacted with the Cell including Departmental policy leads and senior staff as well as the Northern Ireland Hub and Health and Social Care sector [PM/59 INQ000353604 (DoH ref: PM0426)]. There was also a debrief session for core Cell staff, including press office and senior medics. The overall themes explored were:

- Incident response;
- Strategic and policy/subject-specific cells;
- Communication;
- Governance, and
- People and skills.

111. The scope of the findings in the Lessons Learnt Report ranged from 27 January 2020 to 30 July 2020. A total of 20 lessons and recommendations were identified during the review period [PM/60 INQ000188797 (DoH ref: PM5063)]. The majority of the lessons identified were around early engagement with key partners on situational awareness as the emergency evolved, establishing good communications internal and external to the Department, specifically in establishing effective reporting rhythms and developing accurate, timely and relevant Situational Reports from Health and Social Care and Departmental Arm's Length Bodies. Other lessons covered training, resources and defining responsibilities for managing Personal Protective Equipment during a pandemic, including when and how the emergency stockpile is to be used. These lessons and recommendations are all being considered by the Department's Emergency Planning Branch and are being incorporated into the next iteration of the Departmental Emergency Response Plan, currently in progress.

HSC Silver

112. The Public Health Agency, the HSCB and Business Services Organisation, collectively known as HSC Silver [INQ000188753], provided regional coordination of the HSC response to the pandemic. The Silver response was aligned with the strategic objectives set by Health Gold. HSC Silver forwarded, a daily Situation Report (Silver SitRep) to the Emergency Operations Centre Situation Cell, which provided validated key information and data on the situation. This daily Silver SitRep allowed the HSC to identify issues that should be escalated to the Department, whether to seek strategic advice or to require a strategic decision; and it provided the Department with an overview of the key issues in sufficient detail to keep Health Gold informed and to enable strategic decisions to be made whenever necessary. The information was entered into reporting and decision logs [PM/54 - INQ000130312 (DoH ref: PM0037)] which were maintained by the Emergency Operations Centre.

113. During the initial response to the pandemic there was also a regular meeting of the Health Gold/HSC Silver by way of teleconference (also referred to as Gold-Silver calls). This meeting dealt with issues for resolution, and associated decision-making, and was chaired either by the Deputy CMO Public Health or by the Director of Population Health who was also an Emergency Operations Centre Lead. This meeting facilitated the sharing of information between Health Gold, HSC Silver and HSC organisations, and enabled key issues to be discussed and actions agreed. If an issue could not be resolved, or required strategic advice/decision, it was escalated to the Strategic Cell with HSC Silver or policy cell leads providing supporting papers as required. The structures, reporting mechanisms and meetings referenced above ensured that the appropriate HSC ALBs were involved in the core decisions made in response to the pandemic in the early weeks and months of the emergency.

114. The overall operating environment for staff working within Health Gold and HSC Silver was characterised by their working long days and weekends while managing an evolving situation and addressing the risks and uncertainty presented by the pandemic. This required dynamic and diligent working by the staff to ensure that effective measures were in place in NI to protect and inform the public.

Health Silver Debrief

115. The Health Silver debrief was facilitated to inform the overarching Departmental debrief. The debrief took place over two sessions: session one being the 'Contain' phase which had been led by Public Health Agency, and session two was the 'Delay' phase which had been led by Health and Social Care Board.

116. Attendees from the three organisations that make up Health Silver attended both sessions – the HSCB, PHA and BSO. The report of session two was shared with the Department in September 2020 [PM/61 INQ000188798 (DoH ref: PM5064)]. At the time of writing, we have been unable to locate any record of the Department having received the Public Health Agency's report on session one, the 'Contain' phase, and therefore the information below relates to the report of the Health and Social Care Board on session two, 'Delay' phase.

117. The structure of the event was a series of questions posed and discussed with attendees, facilitated by the Emergency Planning leads of the Public Health Agency and the Health and Social Care Board. Topics which were discussed included:

- What went well;
- What could be changed/improved;
- Whether roles and responsibilities were clearly understood;
- Adequacy of staffing and resources;
- Communication with the Health and Social Care sector (Silver/Department of Health);
- Reporting (Battle Rhythm)/Meetings structure and frequency;
- Data availability/SitReps;
- Decision Making – Silver/Gold (to include timeliness);
- Governance- Leadership and Accountability, and
- Key challenges moving forward.

118. The report of session two recognised that many of the areas that gave rise to concern early in the pandemic (staffing, SitReps, reporting/battle rhythm) were rectified as the response to the pandemic evolved. For example, staffing was highlighted as inadequate at the beginning with over-reliance on a select few members of staff, but this improved from March 2020 following the establishment of a core team which ensured a seamless flow of information on a daily basis. Sitrep formats were also revised and developed to take account of the developing situation and changing demands for information. In a similar vein, the reporting/battle rhythm developed over time, with the timing of daily meetings adjusted to ensure key issues could be escalated on the same day to Health Gold.

119. The report identified a number of areas where changes and improvements could be made, for example to ensure lines of communication were clearer and to reduce parallel working. Issues identified with procurement and distribution of Personal Protective Equipment are discussed more fully in Section H, above.

120. The report of the Health Silver debrief session two [PM/61 INQ000188798 (DoH ref: PM5064)] included a series of recommendations. At the time the report was shared, in September 2020, the Department, the HSCB, PHA and BSO remained heavily involved in managing the ongoing pandemic response with ongoing capacity issues. There was therefore no opportunity for the organisations to meet to reflect on the findings from the Health Silver sessions, to review the report, make corrections, develop a shared understanding, or to specifically discuss the points raised and how to address them. However, the Department had in many cases identified similar issues, informed by the 'In flight' review and took account of these in developing the approach to the next wave of the pandemic. For example, the temporary "Management Board for Rebuilding HSC Services" (established in June 2020) and the integrated Covid-19 Gold Command structures (established in autumn of 2020) to manage the second wave of the pandemic recognised the point made in the Health Silver debrief session two report that Covid-19 was no longer an 'emergency' but rather it needed to be incorporated into a new way of doing business. The structures that replaced Health Gold took a more integrated approach than had been taken during the initial emergency response phase, with subject specific cell membership drawn, not only from the Department, but also from counterparts in the HSCB, PHA and BSO.

Modus Operandi Document

121. Due to the unprecedented nature of the pandemic, the complexity of the response and the number of workstreams required, it was felt that it would be useful to draft a Modus Operandi document [PM/62 - INQ000103635 (DoH ref: PM0039)] to reflect in detail how the emergency planning structures, and processes had been adapted in response to the Covid-19 situation. This included the bespoke arrangements put in place within Health Gold, a diagrammatic illustration of structures and accompanying narrative description. The Modus Operandi was agreed in March 2020 by the Strategic Cell to supplement the Department's Emergency Response Plan.

STATEMENT PART 3: THE FIRST WAVE

122. There is no agreed definition of what constitutes an epidemic wave. However, the number of Covid-19 positive hospital inpatients in NI rose from early March 2020, peaked in early/mid-April, and fell to a low level in July 2020. The gravity and rapid development of the evolving situation, in this, the "first wave", was illustrated in a series of statements which the Minister made to the Assembly dated 26/02/20, 28/02/20, 2/03/20, 09/03/20 and 19/03/20 [PM/63 - INQ000103636 (DoH ref: PM0040)], [PM/64 - INQ000103637 (DoH ref: PM0041)], [PM/65 - INQ000103638 (DoH ref: PM0042)], [PM/66 - INQ000103639 (DoH ref: PM0043)] and [PM/67 - INQ000103640 (DoH ref: PM0044)].

123. On Wednesday 26 February 2020 the Minister informed the Assembly that the Department had issued updated guidance to health care professionals on 25 February 2020 [PM/68 - INQ000103641 (DoH ref: PM0045)]. The Minister further advised the Assembly that guidance for other NI Executive departments and their respective public services delivery bodies, including schools, was being updated and would issue shortly.

124. On Friday 28 February 2020 the Minister informed the Assembly of NI's first presumptive positive result for Covid-19, which had been identified the previous day on 27 February 2020 in an individual who had recently travelled to an affected area. PHA personnel were working rapidly to identify any contacts which the individual had, and that process was at an advanced stage of completion. Robust infection control measures were in place to prevent possible further spread of the virus. Members of

the public who had symptoms and who were concerned that they may have Covid-19 were urged not to turn up at GP clinics or hospital Emergency Departments. Instead, they were advised that they should contact their GP or GP out of hours service. A helpline had also been established to provide advice. This was further developed and on 28 February 2020 a dedicated NI helpline was created with NHS 111. The Department and the PHA continued to provide updated guidance to health care professionals and other Departments and their authorities, including schools, as and when necessary. The CMO briefed a number of school principals to underline the advice to schools.

125. In a further statement on 2 March 2020 the Minister updated the Assembly that the individual with the first presumptive case had been confirmed as positive for Covid-19. Contact tracing of those who had come into close contact with the individual since their return from Europe, via Dublin, was immediately undertaken by the Public Health Agency and they were provided with appropriate advice. Once the details of the case were known, the PHA immediately contacted their counterparts in the Republic of Ireland to provide all relevant information regarding the individual's movements while in Dublin. The Minister also advised the Assembly that, as of 2 March 2020, 150 Covid-19 tests had been carried out, 149 of which were negative and 1 was positive. The PHA had been publishing the number of tests on a weekly basis but would move to twice weekly updates. Daily reporting commenced from 24 March 2020. On Friday 28 February 2020 the Minister updated the First Minister and deputy First Minister and on Saturday 14 March 2020 along with the First Minister and deputy First Minister, he spoke with the Taoiseach Leo Varadkar TD, and the Republic of Ireland's Health Minister, Simon Harris TD, in relation to the case. The Minister informed the Assembly that the NI and Republic of Ireland administrations were agreed that the relevant authorities, north and south, should continue to work closely with each other to ensure that where possible, both jurisdictions made the best use of their collective resources when responding to Covid-19.

126. In an Oral Statement to the Assembly on 9 March 2020 the Minister updated MLAs on the number of tests that had been completed in NI together with the number of presumptive cases to date. The Minister further advised the Assembly that the Department would be moving to daily reporting of cases, as currently happened in England. He continued that while the overall risk to individuals in NI remained at moderate, his Department remained focused on containment at this time and then to delay and mitigate. He also reported that the First Minister and deputy First Minister

had been in discussion with their counterparts across the UK at a Cabinet Office Briefing (COBR) meeting that morning to consider the scientific evidence which would guide government in the next steps. Those next steps were aimed at: flattening the peak of the outbreak in the UK; delaying the spread and the impact on the health service; pushing the peak away from this time of year, in order to protect those most at risk.

127. Initial reports from China in January 2020 indicated that Covid-19 led to worse outcomes amongst older men. Over the succeeding months additional data emerged from China, and later Italy, which suggested that people with certain underlying conditions were at increased risk of death and disease. As cases began to appear in the UK, the First Few Hundred (FF100) surveillance protocol provided basic information about the clinical presentation of the first cases and a description of the people affected. This provided early indications of key populations at greater risk. Later hospital admission data confirmed the increased risk of hospital admissions for older adults and in particular older men including those with certain underlying conditions and this was also reflected in Intensive Care admissions. Further details of this are considered in Section 2 of the UK CMO Technical report [PM/69 - INQ000217254 (DoH ref: MMcB001)] including the measures taken in mitigation.

128. There were discussions ongoing throughout March 2020 and across the UK on identifying those at most risk (further information on how the development of the Department's policy was informed is contained in paragraph 274 below). By the 25 March 2020 the Department had written to GPs identifying a list of diseases and conditions considered to be very high risk. GPs and hospital specialists could also identify, on a case by case basis, those they judged to be "high risk" and as evidence emerged, subsequently the definition of CEV was amended.

129. By early March 2020, extensive work had been undertaken to ensure all HSC Trusts had Covid-19 facilities in place to enable patients suspected of having Covid-19 to be assessed and treated away from routine hospital work. The Minister further confirmed that the Department continued to review the best use of testing and clinical pathways so that individuals would receive the appropriate care, whilst recognising that many patients would have a mild illness. The Minister outlined to Members the new structures that the Department had established to plan for the anticipated surge in hospital admissions.

130. The Minister further advised that he remained in close contact with the other UK Health Ministers as well as his Executive colleagues on all developments. Twice weekly COBR meetings were planned to ensure that the joined-up approach to tackling the pandemic continued. Additionally, the Minister confirmed that the HSCB would continue to liaise with its counterparts in the Health Service Executive in the Republic of Ireland to ensure that where possible, both jurisdictions could make the best use of their collective resources when responding to Covid-19. The Minister also referred to the UK-wide Coronavirus Action Plan, published on the 3 March 2020, which set out what the UK as a whole has already done, and planned to do further, to tackle the current Coronavirus outbreak.

131. Finally, the Minister ended his statement, saying: "*it is vital that we keep taking a balanced, proportionate approach at all times, with our actions based on the best scientific advice. Our primary focus remains on containment at this time and then to delay and mitigate. Mr Speaker, let me underline some key points that should offer a level of reassurance. The current evidence is that the vast majority of cases appear to be mild and make a speedy recovery. Decisions will be based on the most up to date scientific and medical advice. We can expect significant ongoing increases in the numbers of people testing positive for Covid-19 in Northern Ireland. The same can be said in England, Scotland, Wales and the Republic of Ireland. Health systems across the globe are coming under extreme and increasing pressure as this virus spreads. Ours will be no different. This is bound to take its toll. Normal business in health and social care may not be possible. Some activities may unfortunately have to be scaled back, but such decisions would not be lightly taken*".

132. The Minister's statement of 19 March 2020 [PM/70 - INQ000120703 (DoH ref: PM0046)] concluded his series of updates to the Assembly throughout the month of March. As with his previous four statements, his focus was on informing Members of the planning underway to respond to the anticipated adverse impact of the pandemic on health and social care services in NI. The Minister informed the Assembly of the planning assumptions available to the HSC in a reasonable worst case scenario and of the actions taken across the HSC system to prepare for the impact of Covid-19, set out in the four weeks summary plan, see paragraphs 312 to 318 below, published by the Department on 19 March 2020 covering the period mid-March to mid-April. The actions in the Plan aimed to ensure that there would be sufficient capacity (including testing, critical care, workforce, ventilators and personal protection

equipment) within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. In addition, he advised that the Department would be sending further detailed and targeted advice to those of all ages at very high risk in the days ahead.

133. As with other countries, the preparations for a surge in demand in NI required the cancellation or postponement of non-urgent appointments, investigation and procedures across outpatients, day case, impatient and diagnostic services. Based on the feedback from the Surge Planning workshop held on 5 March 2020 [PM/71 - INQ000325164 (DoH ref: PM0359)], see paragraph 260 below, the HSCB Director of Commissioning issued follow up correspondence to all HSC Trusts on 10 March 2020 [PM/72 - INQ000325165 (DoH ref: PM0360)]. This requested indicative patient numbers by specialty and the rationale for any proposed downturn of planned elective procedures, and any reduction in outpatient clinics. Subsequently, arrangements were put in place for a daily HSC Trust submission to the HSCB covering elective cancellations. In support of this an updated technical guidance document, with Covid-related cancellation codes[5] was agreed in early March 2020 [PM/73 - INQ000325166 (DoH ref: PM0361)]. Following the issue of the guidance document, the HSCB convened a regional telecall on 18 March 2020 between information managers in each of the five HSC Trusts and the Department to clarify the data on elective cancellations which was to be regularly returned in the data submission. This was followed up by e-mail [PM/74 - INQ000325167 (DoH ref: PM0362)], [PM/75 - INQ000325169 (DoH ref: PM0363)] and HSC Trusts were asked to submit data up to and including 19 March 2020, with daily reporting to be provided thereafter. Data on elective cancellations was then reported on the Daily Covid-19 Report from April 2020 to December 2022 [PM/76 - INQ000325170 (DoH ref: PM0364)]. The Daily Covid-19 Report was circulated to senior officials within the Department, PHA and HSCB at that time, including the Minister. This report was intended to provide internal supplementary information to the Covid-19 Dashboard to help quantify the impact on services.

134. It would have been a matter for the clinical teams to assess impact as part of their decision making and Trusts remained accountable for patient care. It was not for HSCB to assess impact in this context.

[5] Cancellation codes specify the individual reasons for the cancellation of procedures.

SECTION E: THE DEPARTMENT'S STRATEGIC RESPONSE

135. Alongside the preparation of the Executive's 12 May 2020 Recovery Plan, the Department developed a Covid-19 Emergency Response Strategy [PM/77 - INQ000130409 (DoH ref: PM0299)] and an Actions/Metrics document. The Covid-19 Emergency Response Strategy focused on seven broad strategic aims, which were: understanding the likely path of the curve; measures to flatten the curve; understanding the current outbreak; enhancing capacity and building resilience in the HSC; influencing behaviour and providing assurance to the public; enhancing and evolving treatment options; and understanding the wider health and economic impact of control measures.

136. Herd immunity as a potential means of responding to the Covid-19 pandemic was never considered as a strategic response by the Department.

137. As SARS-CoV2 was a new virus many of the important policy decisions early in the pandemic had to be taken when much less was known about the virus, including modes of transmission, the relative importance of asymptomatic infection, common transmission settings, and severity of disease and mortality across the population including in respect of those most at risk.

138. At this early stage in the first wave of there was no means to measure levels of antibodies against the virus, or to assess the extent of immunity, and there was limited virus testing to assess incidence and prevalence. In addition, there was a clear view that allowing the epidemic to spread unabated would have resulted in hospitals being overwhelmed in the short term, and substantial mortality.

139. It was also the case that the population had not previously encountered the virus, had little or no immune protection, and the number of people experiencing severe disease and deaths was likely to be high. The development of "herd immunity" was never considered as a viable strategic response to the pandemic by the Department or the Executive. The level of transmission in the early stages of the pandemic required the extensive use of NPIs and "lockdown" to get R below 1, the approach which had been agreed by the Executive. This was necessary to prevent excessive deaths and to prevent the health service being overwhelmed.

140. However, as the epidemic proceeded, the Department was clear that a high level of population immunity was needed to allow other measures to be completely relaxed. The strategy was to achieve population immunity primarily through high levels of Covid-19 vaccination. It was also recognised that in addition to high uptake of the vaccination, natural exposure to the virus would also contribute to levels of population immunity, although this was never part of the strategic response of the Department. The Department's strategic intent was to achieve a high degree of population immunity, through the Covid-19 vaccination programme, as quickly as possible, with restrictions as limited as possible, while avoiding the hospital system becoming overwhelmed.

141. The Actions/Metrics document outlined progress against the delivery of the Department's Covid-19 Emergency Response Strategy. On 29 March 2020, the Minister wrote [PM/78 - INQ000130407 (DoH ref: PM0297)] to the First and deputy First Ministers emphasising the need for a cross-Executive response to address the impacts felt by all sectors and all levels of society in order to manage the broader societal response to the pandemic. The Minister sent a further letter on 30 March 2020 [PM/79 - INQ000130408 (DoH ref: PM0298)], with the Department's Emergency Response Strategy to Covid-19 [PM/77 - INQ000130409 (DoH ref: PM0299)], and at the Executive meeting, also on 30 March 2020, he and the CMO briefed the Executive on the Strategy.

142. The following sections of this statement set out the key actions taken by the Department during the first wave of the pandemic concerning the development and implementation of NPIs and other emergency measures designed to mitigate the impact of the virus on the NI population and the HSC. These decisions relate to three broad areas of policy response, namely: the public health response; the healthcare system response; and the social care system response.

143. The following sections also cover the Department's decision-making process, cooperation with other jurisdictions, and the information available to the Department concerning Covid-19 which informed our strategic and policy response to the pandemic.

144. During the first wave, and in particular the initial emergency phase, officials were operating within a fast moving, evolving situation, often requiring rapid decision-making. While there would have been bilateral and group discussions involving

officials and the Minister leading up to the taking of key decisions or reflecting upon important information provided by a range of sources, we would not consider these exchanges as being either informal or private communications.

Access to Information and Expert Advice

145. The CMO agreed a proposal by the Chief Scientific Adviser to establish a NI Group, for the purpose of specifically focusing on scientific evidence.

146. The Department's Strategic Intelligence Group was a key source of advice and expertise to inform the HSC response to the pandemic. It was established in March 2020 and chaired by the Chief Scientific Adviser. The details of its membership and terms of reference are provided in [PM/80 - INQ000103642 (DoH ref: PM0047)].

147. The Strategic Intelligence Group was to consider scientific and technical evidence emerging from SAGE and other sources alongside NI data on the trajectory of the pandemic, much of which also fed into NI modelling. The evidence and analysis considered by Strategic Intelligence Group informed the Chief Medical Officer and the Minister. Further, the advice provided to the NI Executive aided with decision making during the pandemic, particularly in respect of the potential impacts of Covid-19 in NI and the approaches to mitigating these.

148. Decisions about NPIs made by the Executive were informed by scientific evidence. The evidence relating to the effectiveness of NPIs in limiting the spread of SARS-CoV2 and reducing hospital pressures was included in the Department's papers to the Executive and was based primarily on advice from the CMO and the CSA. The CMO and the CSA principally sourced their scientific advice from SAGE, although a range of other sources of evidence were considered, including from the World Health Organisation, European Centre for Disease Prevention and Control, The US Food and Drug Administration, and the wider scientific and grey literature [6]. As the pandemic progressed, evidence generated in NI was also considered. Much

[6] Materials and research produced by organisations outside of the traditional commercial or academic publishing and distribution channels. Common grey literature publication types include reports (annual, research, technical, project, etc.), working papers, government documents, white papers and evaluations.

of this evidence was considered by the Strategic Intelligence Group and discussions there informed the advice provided by the CMO and the CSA.

149. Public Health England was not a source of evidence, which was specifically relied on, over and above other sources, and rather was just another source which may have fed into information provided to and discussed by Public Health England at SAGE or its subgroups.

150. In March 2020 the CMO commissioned the newly formed Covid-19 Clinical Ethics Forum to develop guidance to assist clinical decision making during the pandemic period, in particular where situations might arise when demand for clinical care exceeded the resources available. Membership was drawn from existing HSC Trust Clinical Ethics Committees and others with relevant experience. The Covid-19 Guidance for Ethical Advice and Support Framework was issued to the HSC in June 2020 [PM/81 - INQ000353597 (DoH ref: PM0365)], with an easy read version later available. During this period the Covid-19 Clinical Ethics Forum also assisted HSC Trust Clinical Ethics Committees in their role to support clinicians in clinical decision making. In July 2020 the Covid-19 Clinical Ethics Forum was re-established as the regional HSC Clinical Ethics Forum with a wider membership base and mandate from the Department's Chief Professional Officers to support HSC Trust Clinical Ethics Committees, improve awareness and training of ethical issues in clinical decision making and to advise the Department on policy.

151. The details of other Departmental or HSC groups, which provided information and/or expertise are set out within the subject-specific policy areas covered by the following three sections: the public health response; the healthcare response; and the social care response. In general, these groups executed their responsibilities using routine processes for organising meetings, issuing agendas and recording action points and/or decisions. The information relating to the actions taken by these groups was recorded in Content Manager, the Northern Ireland Civil Service Electronic Document and Record Management system, referred to at paragraph 68 above.

152. The Minister and senior officials participated in or had access to a wide range of policy groups, experts and decision makers at the UK level and with the government of the Republic of Ireland. This involved the exchange of information and expert advice concerning the Covid-19 position in NI, Great Britain and the Republic

of Ireland. These interactions helped to inform the Department's strategic and policy response to the pandemic. The details of the UK-level policy groups, expert groups and decision makers are provided in the later sections of this statement.

SECTION F: PUBLIC HEALTH RESPONSE

153. During the first wave of the pandemic the NI Executive made key decisions concerning the public health response to mitigate the impact of Covid-19 in respect of the implementation of NPIs. The Department also kept the Executive informed about decisions taken by it in relation to its departmental response to the pandemic. These decisions are set out below.

154. The Executive's decisions concerning NPIs were informed by the local NI context of the trajectory of the pandemic based on estimates on the 'R' rate (see paragraphs 46 to 47 above) and local modelling. The Department's input to the information and advice presented to the NI Executive was informed by the available information on the trajectory of the pandemic across the UK, which was shared in the discussions among the various UK four nations groups outlined below.

Coronavirus Domestic Restrictions Regulations

155. The Department, with Executive agreement, introduced The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020. These Regulations made provisions to enable a number of public health measures to be taken to reduce the public health risks posed by the spread of Covid-19. The Regulations provided for a range of restrictions and closures, as well as requiring persons to stay home by prohibiting them from leaving the place where they lived except for limited purposes (such as shopping for basic necessities, exercise, to seek medical assistance or to provide care or assistance) and banning public gatherings of more than two people. The Regulations required a review every 21 days (Regulation 2) from 28 March 2020. These Regulations were replaced by The Health Protection (Coronavirus, Restrictions) (No. 2) Regulations (Northern Ireland) 2020 on 23 July 2020. Regulation 3 changed the review period to every 28 days. To allow for Christmas, the review was extended by one week via amendment 20 on 16 December 2020, so the next review was due on 14 January 2021. The reviews returned to 28 days thereafter via amendment no 2 in 2021.

156. The Health Protection (Coronavirus, Wearing of Face Coverings) Regulations (Northern Ireland) 2020 were also made on 23 July 2020 and required a review 6 months after coming into operation.

157. In each review, the Department provided an assessment of the change in case levels over that period and addressed the following areas: the number of new positive cases; Rt[7] for cases; Rt for admissions to hospital; the conversion rate of case numbers to hospital admissions; modelling scenarios for the time ahead; the prevalence of relevant variants; and the case numbers per hundred thousand of the population, broken down by district council area.

158. The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 provided for enforcement of the relevant provisions by the Police Service of Northern Ireland (the 'PSNI) and the Harbour Police; or persons designated by the Department (in respect of Regulations 3 and 4). On 15 May 2020, the Minister designated district councils as additional enforcement bodies in respect of Regulation 3 (viz., the requirement to close premises and businesses during the emergency) and Regulation 4 (in relation to further restrictions and closures during the emergency period). This also allowed for the issuing of fixed penalty notices in respect of contraventions of Regulations 3 and 4.

159. All restrictions on funerals were also contained within The Health Protection (Coronavirus, Restrictions) Regulations (NI) 2020. Following the activation of Health Gold on 9 March 2020 a Death Cell was led by the Acting Director of Head of Quality Regulation and Improvement Directorate, Mr Conrad Kirkwood. Mr Kirkwood was supported by the Department's Death Certification Policy Branch and a medical advisor. From 2 April 2020 onwards, the Death Cell was led by the Head of the Department's Death Certification Policy Branch, **Name Redacted** The Death Cell's key roles were to produce guidance, which included: guidance for funeral directors on handling the infection risks when caring for the deceased and managing funerals; guidance for health professionals on the completion and issuing of Medical

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[7] [7] In epidemiology, the basic reproduction number, denoted R0 of an infection is the expected number of cases directly generated by one case in a population where all individuals are susceptible to infection. The definition assumes that no other individuals are infected or immunized (naturally or through vaccination). In reality, varying proportions of the population are immune to any given disease at any given time. To account for this, the effective reproduction number (Rt) is used, which is the average number of new infections caused by a single infected individual at time t in the partially susceptible population. When Rt is less than 1, the number of cases will begin to rise more slowly and / or decline.

Certificate Cause of Death and Stillbirth Certificates; guidance on Death Certification and Registration; and for Verifying Life Extinct (VLE) during the pandemic [PM/82 - INQ000103643 (DoH ref: PM0048)], [PM/83 - INQ000103644 (DoH ref: PM0049)], [PM/84 - INQ000103646 (DoH ref: PM0050)], [PM/85 - INQ000103647 (DoH ref: PM0038)], [PM/86 - INQ000103648 (DoH ref: PM0051)], [PM/87 - INQ000103723 (DoH ref: PM0246)]. The Death Cell also responded to numerous queries involving Covid-19 deaths from a wide range of organisations and individuals. These included churches, clergy, local councils, funeral directors. Government Departments, PSNI, Coroners, and private individuals.

160. The guidance for Funeral Directors was initially developed in collaboration with the PHA and the National Association of Funeral Directors, and took account of national guidance published by Public Health England and the differing cultural practices and rites of passage observed in Northern Ireland when someone dies. The initial guidance was approved by the CMO and the Minister and was first published on 2 April 2020. As the Covid-19 situation progressed, alongside the greater understanding of the disease and the particular restrictions in place at any time, revisions to the guidance were required on a regular basis.

161. Guidance and advice provided was broadly similar to the other Devolved Administrations however there were some differences in respect of managing and coordinating funerals mainly in relation to the different cultural habits in NI.

162. The National Association of Funeral Directors, district councils, churches and the City of Belfast Crematorium were consulted when amendments were required and each of the revised versions were approved by the CMO and the Minister prior to issue and publication.

163. The Department's development of policy related to the above domestic restrictions and NPIs was informed by the Minister's and officials' participation in UK information sharing groups. The Minister and CMO attended meetings of COBRA. The Minister participated in a regular UK Four nations health ministers meeting. The UK Chief Medical Officer meetings, attended by CMOs and Deputy CMO from the respective jurisdictions, took place nearly every day in 2020, approximately 3 times per week in 2021 and weekly in 2022. There were also meetings of UK Senior Medical and Nursing Clinicians, meetings of SAGE and related subgroups, at which the Department was represented.

164. The Department attended a UK counterparts group established by the Home Office in April 2020, which was later passed to the Department of Health and Social Care to host from August 2020. This group shared factual updates from the four UK countries on amendments or proposed amendments to the Covid-19 restriction regulations. However, the decision making body for amendments to regulations was the NI Executive.

165. The Health Gold Death Cell participated in twice weekly Four nations Calls at the start of the pandemic, to provide updates on the current position, and challenges faced within the funeral industry.

Coronavirus International Travel Regulations

166. The Department, with Executive agreement, introduced the international travel regulations which placed duties on travellers to NI to comply with requirements in relation to completion of the passenger locator form (PLF), purchasing of pre-departure and post arrival testing packages and to self-isolate/ enter in to managed quarantine, depending on the country the traveller arrived from.

167. UK border policy and operations are UK Government reserved matters. However, health policy is a devolved matter, which in NI is the responsibility of the Department, and as such the UK Government had an obligation to consult the Devolved Administrations, including the NI Executive, on health protection measures at the border. The temporary modification of the Public Health Act (Northern Ireland) 1967 by the Coronavirus Act 2020 gave the Department the primary powers to make International Travel regulations. This enabled NI to stand up proportionate border health measures, which were subject to public health advice at that time and Executive agreement. The Department's policy development underpinning these Regulations was therefore informed by information on the risks, associated with international travel, provided from UK Government national analysis e.g., Joint Biosecurity Centre, which took account of the reliability of epidemic surveillance data and quantitative information about numbers. This information was reviewed and considered by the Chief Scientific Adviser / Chief Medical Officer, and advice was subsequently provided to the Minister. The Department also considered any information available on international travellers entering the Republic of Ireland

before transiting to NI, although the extent of this information varied during the course of the pandemic.

168. The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020 came into operation on 8 June 2020. The Regulations applied in relation to travellers arriving into NI from outside the Common Travel Area ((CTA) which includes the UK, ROI and the Crown Dependencies (Jersey, Guernsey and the Isle of Man). Intra CTA travel was exempt from the requirements under the Regulations unless a person had been outside the CTA within the last 14 days of entry into NI. The regulations required a person arriving into NI who had been outside the CTA within the last 14 days to complete a UK passenger locator form and to self-isolate.

169. Public health protection policy is a devolved matter which in NI is the responsibility of the Department. This included the: maintenance of public health information and advice in relation to travel to and from NI and within the Common Travel Area; and liaison with Home Office (Border Force) in relation to compliance by Carriers/Operators (airlines and cruise operators) to NI in relation to restrictions and information to passengers.

170. Some aspects of policy in this area could be deemed to be cross-cutting between the UK Government and the Devolved Administrations. For example, in NI the enforcement of measures was the responsibility of the Home Office Border Force and the Police Service of Northern Ireland, with the Public Health Agency providing advice in relation to Port Health.

171. A Passenger Locator Form had to be completed by all passengers prior to international travel capturing details of the passenger, the address they were staying, their vaccination status (from 4th October 2021), their contact details and details of countries they had travelled to in the previous 10 days.

172. Border Force officials were given powers to issue fixed penalty notices to those arrivals who did not comply with the requirements in relation to the Passenger Locator Form and testing, and the Police Service of Northern Ireland were given powers to direct a person who did not comply with the self-isolation requirements to

return to the place of isolation or to remove them to the place of isolation. A fixed penalty notice regime was also created in relation to these offences.

173. While not in legislation, NI provided guidance [PM/88 - INQ000145667 (DoH ref: PM0097)], [PM/89 - INQ000145703 (DoH ref: PM0345)]] for individuals travelling within the Common Travel Area (being, the UK, Guernsey, Jersey, Isle of Man or the Republic of Ireland). The guidance requested that if travel involved staying overnight in Northern Ireland, a rapid lateral flow device test should be taken before beginning the journey, only travelling if the test was negative and the individual was not suffering from any Covid-19 like symptoms. Completing a passenger locator form was not required unless the individual had been outside the Common Travel Area in the previous 10 days. The guidance also recommended taking post arrival lateral flow device tests as well.

174. Under the terms of the Memorandum of Understanding entered into on 7 April 2020 by the Departments of Health, and their respective agencies, from NI and the Republic of Ireland: 'Covid-19 Response – Public Health co-operation on an All-Ireland Basis', the two Departments had weekly meetings jointly chaired by the CMOs of NI and the Republic of Ireland. The meetings were attended by the CSA from NI and Deputy CMOs from both jurisdictions and respective subject-specific policy lead officials. Data was shared in relation to the pandemic trajectory and information concerning the policies covering international travel in relation to border health measures. These discussions helped to inform policy but as described above, border policy is a reserved matter and NI could not itself legislate in relation to the ROI border.

175. Engagement took place at official level between the Department and the Republic of Ireland from May 2020, in meetings between the respective CMOs, to agree data collection from the Republic of Ireland's Passenger Locator Form. This was necessary due to the need to identify those international travellers transiting through the Republic of Ireland to NI to enable the Public Health Agency to contact these travellers to remind them of the legal requirement to complete a UK Passenger Locator Form, and to advise on the health regulations in place. Engagement between policy officials also took place to put into operation a data sharing agreement between the two jurisdictions. This included agreeing an interim arrangement, pending the completion of a data sharing agreement. The terms of this interim

arrangement was that the Republic of Ireland's Department of Health would use the existing data collected from its Passenger Locator Form to provide a follow-up SMS text message service to international passengers arriving into Ireland and transiting to NI using its existing system for follow up contact with passengers. The message pointed individuals to the NI Direct website, reminding them of the legal requirement to complete a UK Passenger Locator Form and of the NI health regulations in place. Whilst this interim solution did not substantively address NI's inability to contact these travellers and ensure they were self-isolating; it did allow the Department to ensure that travellers were fully informed of their legal requirements. The Department paid a fee to the Republic of Ireland's Department of Health for this service. The final Data Sharing Agreement between the Public Health Agency in Northern Ireland and the Minister for Health (Republic of Ireland) Ireland was signed on 15 October 2021 [PM/90 - INQ000346692 (DoH ref: PM0366)]. There were no additional arrangements in place for arrivals into Northern Ireland who were travelling onwards to the Republic of Ireland, NI Direct travel pages at that time advised that anyone travelling outside NI should comply with the travel requirements for entry into that country.

176. Those who travelled to NI, having entered via the Republic of Ireland, had to complete both an Irish Passenger Locator Form and a UK Passenger Locator Form. In October 2021 the Department of Health in NI and its counterpart in the Republic of Ireland finalised a data sharing agreement [PM/91 - INQ000120715 (DoH ref: PM0099)] for the Republic of Ireland Passenger Locator Forms, which was designed to mitigate the risk of a passenger entering NI, via the Republic of Ireland, and not adhering to NI's public health measures e.g., self-isolation and/or testing. Both departments developed a Short Messaging Service that notified travellers crossing the border of the requirement to complete both documents. However, even with this agreement in place, difficulties in regulation across the land border occurred. For example, in November 2021 a sports team from Great Britain returning from an international trip landed in Dublin but was not required to undertake quarantine in the Republic of Ireland, and had to make a long journey to the quarantine facility in Antrim in NI by coach instead.

177. The Department recognised that people would travel across the border for many reasons including work, such as healthcare workers, and visiting family and friends. The Minister provided advice from the CMO and the CSA on cross border travel to the Executive. This involved public health advice to the population to travel

only if essential for work purposes and not to do so if symptomatic. Health care workers were participating in a regular asymptomatic testing at this time.

178. A further example of action taken by the Department concerning cross-border travel involved the response following the emergence of the Alpha variant. In an oral statement to the Assembly Ad Hoc Committee on 21 December 2020 the Minister informed the Assembly of the emerging situation with regards to the variant strain, which had been detected most prevalently in the South East of England [PM/92 - INQ000276594 (DoH ref: PM2270)]. This variant was identified following proactive and enhanced epidemiological analysis in response to the increase in cases seen in Kent and London. In his Executive paper of 21 December 2020 [PM/93 - INQ000276561 (DoH ref: PM2241)], the Minister set out advice concerning this variant, provided by the CMO and the CSA, that whilst the absolute risk of travellers from the rest of UK having Covid-19 was low, and even lower for the new variant, there would be merit in limiting or temporarily banning travel if the variant was not present in NI. While the presence of the new variant could not be confirmed, there were strong indications that it was present in NI. In the absence of definite evidence, a precautionary approach was advised, which included possible consideration of limiting travel from the Republic of Ireland given the current disease trajectory and low level of genotype sequencing. The Minister expressed his view that the Executive should immediately issue guidance advising against all but essential travel between NI and Great Britain/Republic of Ireland, with immediate effect, including asking all new arrivals to self-isolate for 10 days following entry to NI. The overall approach was to seek to delay the introduction of any new variant while assessing its potential significance.

179. In its statement of 21 December 2020 the Executive urged everyone to travel only if it was absolutely necessary. The statement made clear that travel was not permitted in or out of Tier 4 areas in England. It went on to state that restrictions applied in other tier areas and that everyone should comply with all travel restrictions in place for each region and check the guidance at both the point of departure and destination.

Review of the International Travel Regulations

180. The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020 No. 90 placed a duty on the Department to review the need for the requirements imposed by these regulations at least once every 21 days. The first review took place on 29 June 2020. As NI had moved to a situation where local incidence and prevalence was much lower than it had been, imported cases could become a higher proportion of the overall number of infections, and so measures taken to prevent the introduction of imported cases were considered to have a greater potential benefit. The review was brought to the Executive for consideration using the most recent data analysis and public health advice in relation to trajectory of the pandemic in NI. Taking these matters into account, the Executive agreed there was a need to retain the regulations. Further reviews of the regulations took place on 20 July 2020 and 10 August 2020, during which the Executive agreed that travel regulations were still required. On 20 August 2020 the review period for these regulations changed from 21 days to 28 days in line with domestic restrictions regulations and the other Devolved Administrations.

181. Cross-cutting policy decisions requiring Executive approval were included in subsequent amending regulations with further minor amendments i.e., additions/ removal of countries from travel corridor lists made without referral but notified to the Executive. Following the fourth review, on 7 September 2020, the Executive agreed, that due to the increasingly regular basis that the regulations were being amended, in relation to the addition and removal of travel corridor list countries; any further amendments made to the Travel Regulations would also be considered a review. This change to the regulations was made on 3 October 2020.

182. Due to the nature of the pandemic and the urgency in which the regulations had to be made, it was often the case that scrutiny of the regulations by the Assembly's Health Committee took place after the regulations came into operation. Departmental officials were invited to attend the Health Committee sessions to provide verbal evidence regarding the advice and information which informed the Executive's decisions.

183. The development of the Department's policy (as it related to the above International Travel Regulations) was informed by the Minister's and officials' participation in UK information sharing groups. Officials from the Department's

International Travel Directorate attended a range of groups. These groups included: the Border Health Measures Board (which was chaired by the Cabinet Office covering all aspects of international travel and the future of border controls); the UK Government/Devolved Administrations International Travel Programme Board (which was chaired by the Department for Transport, and discussed UK Government policy changes and new proposals being brought forward for decision at Covid-19 Operation Committee meeting. The Covid Operation Committee was set up to deliver the policy and operational response to Covid-19 and was chaired by the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office. The Chancellor of the Exchequer, Secretary of State for Health and Social Care and other Cabinet Ministers were invited according to the agenda (including Devolved Administration Ministers). The UK Government/Devolved Administrations International Travel Programme Board also discussed the position of the Devolved Administrations on alignment with UK Government policy.

184. The Minister attended Covid Operational Committee meetings, dealing with international travel, which included Ministers from the other Devolved Administrations before final decisions about NI Travel Regulations were made. Departmental officials attended pre-meetings usually scheduled 24 hours beforehand to discuss the policy decisions to be discussed at the Covid Operational meeting and the issues arising.

185. The Department's officials also attended regular meetings of the UK Government/Devolved Administrations Travel Group led by the Department for Transport. These meetings enabled the Devolved Administrations to share their views on policy proposals from the UK Government's Covid-19 Global Travel Taskforce. The exchange of views informed the Department's advice to the Minister of the position being taken by the other Devolved Administrations on some of the international travel measures, including the completion of the Passenger Locator Form and post-arrival Covid-19 test booking platforms. Departmental officials also attended the fortnightly meeting of the Passenger Locator Form Working Group, chaired by the Home Office, which discussed changes to the Passenger Locator Form in the light of any travel policy/regulation changes or general improvements to the form, and enforcement measures at the border.

186. The Department's officials attended the Department of Health and Social Care/Devolved Administrations Managed Quarantine Service/Border Health Measures checkpoint meeting. This meeting discussed any planned changes to red

list country arrivals and policies, the policies on testing and the Managed Quarantine Service. The Managed Quarantine Service/Department of Health and Social Care Contractor meetings were held with varying frequency, sometimes daily. The contractor meetings provided an awareness of operational matters such as contract handovers, stock, information on bookings, occupancy and testing compliance in the local Managed Quarantine facilities.

Schools

187. During the pandemic the approach to schools was one of the more challenging areas given the recognised educational, social and health benefits to children of being in school, and the significant contribution of education in improving life chances and in reducing health inequalities and disparities experienced by children. The task of maintaining children in schools while reducing the risks of transmission and outbreaks with consequential schools' closure was complex.

188. Schools in the Republic of Ireland closed on 13 March 2020 whereas the decision to close schools in England, Scotland and Wales and Northern Ireland was announced on the 18 March. Schools across the UK closed from Friday 20 March 2020 and in NI all schools closed to pupils from Monday 23 March 2020. The first attendance restrictions in Northern Ireland came into place on 20 March 2020, however schools did remain open for face-to-face learning for vulnerable children and the children of essential workers. . The Department of Education can provide further details of the operational implementation.

189. In announcing its decision on 18 March 2020, the Executive acknowledged that: "*our school principals, parents and pupils have been in a holding pattern based on medical advice for the last week. Today we have agreed that all schools will close from Monday the twenty third of March…Our medical advice was to delay this step for as long as possible as the closure will likely take us beyond the natural break for summer*". The Executive acknowledged that Northern Ireland was the only part of the UK with a land border with another state, with the concomitant difficulties of children attending schools across the jurisdictions. At a meeting on 13 March 2020 the Executive had discussed the appropriate timing of the closure of schools, given the different approaches to this matter in the Republic of Ireland.

190. The difference in the timing of the decision on schools' closure between NI and the Republic of Ireland was the source of political and media commentary. However, decisions in respect of the timing of the closure of schools and coordination of closures with the Republic of Ireland were ultimately matters for respective Ministers. The Department provided advice to the Minster, which the Minister then brought to the Executive, including the Minister for Education, to inform a decision by the Executive in relation to school closures. The health advice which informed the decision by the Executive to close schools in NI and the timing of closure was based on a range of factors, including the expert medical and scientific advice available from the Scientific Advisory Group for Emergencies (SAGE); European Centre Diseases Prevention and Control Guidance; Public Health England and the consideration of that evidence by the CMO. The Department would not normally provide advice on more operational matters or the coordination of any policy decision which would have been for respective Education Ministers. The wider issue of the approach to the closure of schools was a complex matter; the considerations are described more fully in the UK CMO Technical report on the pandemic in the UK, Chapter 8.1, pages 270 to 282 [PM/69 - INQ000217254 (DoH ref: MMcB001)].

191. Key considerations influencing the health advice included: the general epidemiology of the pandemic as documented at the time; available evidence in relation to transmission of infection in school settings; the potential impact on availability of healthcare staff to provide health and social care due to the need to care for their children; and the potential for secondary spread to a more vulnerable population in circumstances where older grandparents could be asked to care for children when schools were closed, consistent with advice from SAGE and ECDC [PM/94 - INQ000346693 (DoH ref: PM0369)]

192. At the start of the pandemic the short-and longer-term impacts of Covid-19 on children in general were not known although children were observed to have generally milder symptoms. Nor was the role that children played in the transmission of Covid-19 fully understood or indeed the relative contribution that transmission of infection in the school setting played as distinct from transmission in the home or through other social contacts. In the early stage of the pandemic there was significant debate as to whether school restrictions and/ or school closures were necessary in addition to other NPIs, and this uncertainty was reflected in SAGE

discussions. While undoubtedly mixing in schools provided opportunity for transmission of the Covid-19 virus, it was recognised that the closure of schools would have significant implications for children's education and their well-being given the important public health benefits that attendance at school has for children's physical and mental health. In addition, it was also recognised that school closures would be likely to present further challenges in respect of childcare arrangements for essential workers. It was therefore important to try and achieve a balance between no intervention in schools, the risk of increased transmission of the virus and the effect on the health service, and intervention to the extent there could or would be a disproportionate impact on children's education, social development and future life opportunities.

193. In the context of the early evidence available and an assessment of the benefits in terms of reduction in transmission, when weighed against the harm to children and the wider societal impact in early March the CMO, following consideration of the ongoing debate at SAGE about whether school closures would be needed in the first wave in addition to other NPIs particularly given modelling suggestions that any closures would need to be for 8-12 weeks for maximum effect, advised that there was insufficient evidence at that time to advise that the immediate closure of schools was proportionate. The view subsequently taken by SAGE and published its Consensus view 17 March was that while school closures represented one of the least effective single measures to reduce the pandemic peak that they may be necessary to manage NHS Capacity [PM/95- INQ000346694 (DoH ref: PM0370)]. The CMO was fully aware of the emerging SAGE consensus view and reflected this in his oral advice to the Executive which informed the Executive's decision on school closures 18 March.

COVID-19 Test, Trace and Protect Strategy

194. As in the rest of the UK, the Public Health Agency were undertaking contact tracing for all cases of Covid-19 until 12 March 2020.There was a relatively small number of cases at this time therefore contact tracing had the potential to have significant impact on the course of the epidemic and in delaying community transmission. More generally, contact tracing is most effective when levels of community transmission and numbers of cases are lower. In mid-March 2020 the levels of community transmission were higher which meant, in general terms, the impact of contact tracing as an effective mitigation to help break chains of

transmission and reduce spread was likely to be less. However, as there were many variables influencing and impacting spread and trajectory of the virus, it is not possible to accurately quantify or assess the impact of removing contact tracing on the trajectory of the virus.

195. On the 12 March 2020, the UK Government decided at the COBRA meeting to move from the containment phase to the delay phase. This decision was underpinned by the UK-wide agreed *Protocol for Moving from Contain to Delay* [PM/96 - INQ000346695 (DoH ref: PM0371)]. This was followed shortly afterwards on 23 March 2020 by the introduction of the first UK-wide lockdown. The decision to pause contact tracing was integrally linked to the decisions to move to the delay phase and to introduce population wide lockdown measures.

196. The decision to pause contact tracing, while an operational one, was a decision that would ordinarily have been taken in conjunction with the Public Health Agency and involved consideration by the CMO and discussion with the Minister. The Department continues to review records to obtain contemporaneous evidence of this decision.

197. Moving into the delay phase involved a change to the overall approach to management of Covid-19 – each person developing symptoms (new persistent cough and/or fever) was advised to self-isolate for 7 days, members of their immediate household (close contacts) were also advised to self-isolate for 14 days.

198. The focus of efforts in NI at this time shifted from individual contact tracing to wider measures, including advising the public what to do if they had symptoms, to limit contacts, to stop all non-essential contacts, and the prevention of spread through social distancing. In the context of the general population being advised to 'stay at home' and 'limit their contacts', in addition to specific advice for those who were symptomatic (assumed to be cases), those who tested positive (confirmed cases), and those who were in contact with cases (household and other contacts), the need to individually contact trace all cases lessened. Contact tracing was restricted to high-risk contacts, such as residents in care homes or patients in hospital.

199. The rationale underpinning the change in approach from the containment to the delay phase was based on sound public health principles and recognition that there was widespread community transmission of the SARS-CoV-2 virus. All members of the pubic were informed that the virus was circulating, there were extensive communication campaigns to advise members of the public about symptoms to watch out for and actions to take should they develop symptoms. The application of these population level interventions including the rigorous social distancing measures effectively superseded contact tracing during this 'delay' phase of the pandemic response. All the advice and guidance on preventing onward spread, on self-isolation and on social distancing, which previously formed the basis for the rationale underpinning contact tracing of cases and contacts, now applied to the general population.

200. The decision to pause contact tracing was also informed by a number of other operational factors. This included optimising the use of available testing capacity. Testing capacity at this time was not sufficient to identify all cases that needed to be contact traced and available tests were prioritised for clinical care and in settings with vulnerable people such as hospitals and care homes. This in turn impacted the effectiveness of contact tracing, as only a limited proportion of cases in the community were being picked up through testing.

201. In addition, in the first wave, as case numbers increased rapidly, there were significant challenges in maintaining contact tracing at the intensity and scale required to ensure chains of transmission were interrupted as effectively as possible. The existing contact tracing workforce, resources and systems were not able to handle such a large spike in demand.

202. Following the pause in March 2020, contact tracing was re-introduced in NI on 27 April 2020 through a pilot phase, with the full launch on 18 May 2020. When re-established on 18 May 2020, contact tracing was maintained throughout the rest of the response. At times of very high prevalence, the efficiency and effectiveness of the service was reduced. It should be noted that this decision to reintroduce contact tracing was taken at a phase in the pandemic when there was no vaccine or specific treatments available. In combination with other NPIs the purpose of the Service was to interrupt chains of infection in order to limit community transmission. The overall aim of the Service was to assist in reducing the number of Covid-19 cases, severe disease, hospitalisations and deaths from the virus. The Service also aimed to help

alleviate the associated pressures on the HSC's capacity. At that time this was considered a proportionate response to the pandemic, given the consequences of the infection spreading unchecked in the population.

203. The Department's first Covid-19 Test, Trace and Protect Strategy [PM/97 - INQ000120704 (DoH ref: PM0053)] was published towards the end of the first lockdown on 27 May 2020. The Strategy set out a programme of actions, recognising that testing and contact tracing had a key role in reducing the spread of the SARS-CoV-2 virus, and in doing so, preventing serious illness.

204. The four key elements of the May 2020 'Test, Trace and Protect' Strategy were: early identification and isolation of possible cases, clusters, and outbreaks; rapid testing of possible cases; tracing of close contacts of cases; and early, effective and supported isolation of close contacts to prevent onward transmission of infection. The Strategy acknowledged that these elements would become a part of everyday life in NI until an effective vaccine was developed and a vaccination programme for Covid-19 delivered to the NI population.

205. An Expert Advisory Group on Testing (EAG-T) was established by the Department to develop the NI approach to Covid-19 testing and to oversee and coordinate the implementation of testing. The Department presented its Covid-19 Testing Strategy [PM/98 - INQ000103649 (DoH ref: PM0054)] to the Executive on 6 April 2020 and presented an updated version on 21 May 2020 [PM/99 - INQ000103650 (DoH ref: PM0055)]. The updated Strategy set out how testing capacity had expanded and was being used on a prioritised basis. The Strategy was supported by an Interim Protocol for Testing for Covid-19 [PM/100 - INQ000120705 (DoH ref: PM0056)], PM/101 - INQ000103724 (DoH ref: PM0247)]. The Protocol was an operational tool which provided information on eligibility for testing and advice on how to access testing. The Interim Protocol was kept under continuous review with priority groups for testing extended regularly in line with emerging scientific evidence and with expansions in testing capacity.

206. The ability of NI to design and to evolve its Contact Tracing Service model with agility was an important aspect of the deliverability of the Service in NI. The decision to root the NI Contact Tracing Service in the Public Health Agency was an important one. In doing so, The Department consciously and deliberately connected

the Contact Tracing Service into an agency which already had the Health Protection Function and as part of that function it already undertook contact tracing as a routine part of responding to public health incidents and outbreaks.

207. There were differences across the 4 UK nations' approach to contact tracing, including differences in staffing models. In NI, the Contact Tracing Service was mostly staffed by healthcare professionals such as nurses. This was different to the staffing model across the other UK nations and was unique in the UK. This professional input was vital in helping to contain the spread of the virus for example through conducting risk assessments and managing what could often be complex cases involving clusters and outbreaks. High-risk settings and large outbreaks were risk assessed by the clinical team with oversight by the public health consultant, with more complex situations managed by the core health protection service.

208. Separate teams within the Public Health Agency supported care homes, schools, early years and some other settings, working with the Contact Tracing Service as required. The person-led element of the Service was key to successfully tracing positive cases and their contacts, and was complemented by a number of innovative digital solutions including: the digital self-trace platform which allowed positive cases to enter their close contact details online; a texting service; and the StopCOVID NI App (see paragraph 229 below). All of these component parts contributed to the overall efficiency of the Service.

209. The flexibility of a locally designed and delivered system also enabled the Contact Tracing Service to make operational service delivery changes swiftly and with agility for example when following its Contingency Escalation Plan at times of increasing and extreme demand. The purpose of the Contingency Plan was to set out how contact tracing resources were to be used differently to cope with increasing demand situations ensuring that the most high-risk situations were prioritised and to deliver maximum public health impact from contact tracing resource. The Public Health Agency kept the Contingency Escalation Plan under review throughout the pandemic and it was subject to change.

210. As case numbers rose in spring 2020, staff from other backgrounds were recruited from within the health service and existing Public Health Agency staff were redeployed and trained as contact tracers. Some staff were also retained on an "on call "or "bank" basis to supplement operational capacity as required.

211. The staffing numbers for the Contact Tracing Service fluctuated during the pandemic in response to the trajectory of the virus. For example, a snapshot of the staffing complement (based on management information, provided by the Public Health Agency during the pandemic, shows that in July 2020 there were approximately 90 trained staff, whilst in February 2022 there were 169 Whole Time Equivalent contact tracers (246 headcount). [PM/102 - INQ000346696 (DoH ref: PM0372)]

212. In July 2021, in response to a significant further increase in cases, a revised service delivery model was developed by the Public Health Agency Contact Tracing Service which involved an expansion of the CTS workforce. As part of this new model, a new Health Technician Contact Tracer role was introduced by the Service (HSC Agenda for Change Band 4 level). This change facilitated the introduction of a new triage system whereby a senior contact tracer (HSC Agenda for Change Band 6 level), using a range of live intelligence systems and dashboards available to the Contact Tracing Service, was able to allocate cases to the contact tracing staff. The more complex cases with a higher risk profile were progressed by Band 6 contact tracing staff and the less complex cases to be allocated to the new Band 4 technical grade staff. This approach is similar to that taken in some other clinical settings where the most experienced and skilled staff review the workload before it is allocated to the most appropriate level of staff, helping ensure the most effective and efficient use of available skills and expertise.

213. The Contact Tracing Service deployed a flexible staffing and service delivery model, supported by its Contingency Escalation Plan, which provided the Service with ability to flex as positive case numbers and demand for its service increased. For example, the number of hours undertaken by contact tracing staff (based on management information provided by the Public Health Agency during the pandemic) peaked at a total of 31,975 hours in January 2022 (in comparison for example to 12,381 hours undertaken in October 2020).

214. Manual tracing was also complemented and enhanced by digital solutions including for example the public facing digital self-trace platform which, once details were completed, sent automated SMS messages with public health advice to cases and contacts.

215. In relation to contact tracing capacity, the CSA provided advice to the Public Health Agency on two occasions around the required size of the service. CSA advised the Public Health Agency on 20 April 2020 that he estimated a need for 300 – 600 contact tracing staff would be required in NI, and was assured that over 500 were in training. Based on the European Centre for Disease Control (ECDC) estimates from April 2020, this would have been sufficient for a contact tracing service to handle over 1000 cases per day [PM/103 - INQ000346697 (DoH ref: PM0373)] On 17 September 2020 the CSA met with the Public Health Agency and indicated that the contact tracing service needed to be able to manage 500 cases and 5000 contacts per day. The Public Health Agency indicated that their current business case for the contact tracing service was on the assumption of 50 cases per day. Following a period of ongoing discussion and correspondence with the Department, an updated business case was subsequently submitted by PHA on 3 November 2020 taking account of the CSA advice. Efforts by PHA to recruit additional contact tracing staff was ongoing in the interim pending development and approval of the business case. Further, on 3 October 2020, the Chief Medical Officer commissioned a Rapid Review of the contact tracing service (CTS) and its delivery mode to reflect on the key issues influencing provision of the contact tracing service and to provide assurances on the capacity of the contact tracing system (see paragraphs 220 to 222 below).

216. The SARS-CoV-2 testing programme and contact tracing were key strategic elements of the pandemic response in breaking chains of transmission and reducing community transmission. Both programmes were closely linked, complex and complicated. There were significant logistic and operational challenges which overlapped with policy dimensions in both programmes. For example, testing for SARS-CoV-2 included managing significant and complex contractual and budgetary considerations with respect to Pillar 2 and the UK National Testing Programme to increase testing capacity alongside strategic policy decisions by the Department on advice of the Expert Advisory Group on Testing (EAG-T) (chaired by PHA) on the

most effective approach to testing as described in paragraph 203. Recognising the strategic importance and interdependencies the Department established the Test, Trace, Isolate, Protect Strategic Oversight Board [PM/104 - INQ000137363 (DoH ref: MMcB031)] from May 2020, which was chaired by the CMO. The Board's role was to provide oversight of both the contact tracing and testing programmes. This included the sharing of intelligence on clusters and outbreaks and providing advice in terms of policy implementation and its effectiveness. In April 2022 the Board's Terms of Reference were updated to oversee implementation of the Covid-19 Test, Trace and Protect Transition Plan [PM/105 - INQ000137364 (DoH ref: MMcB032)].

217. Given the collaborative approach between the PHA and the Department the establishment of the Board ensured a highly effective and efficient interface between policy and operational teams particularly as the approaches to testing and contact tracing continued to evolve throughout the pandemic response. The establishment of the Board also ensured that the Department was able to provide assurances and regular updates to the Minister and the Executive of the effectiveness of both the testing and contact tracing programmes.

218. Testing was a critical part of NI (and the UK's) pandemic response. The Department increased NI's testing capacity significantly through the formation of new partnerships to deliver on this, both locally (through the Scientific Advisory Consortium – as part of what was known as Pillar 1), and nationally (under the UK National Testing Programme - known as Pillar 2 - which was procured and contract managed nationally on behalf of UK nations by the Department of Health and Social Care and latterly by the UK Health Security Agency. The role of the Expert Advisory Group on Testing (EAG-T) was critical to advising on and delivering the expansion of testing capacity, and in managing relationships on an ongoing basis. This included exploring all available options to rapidly increase laboratory testing capacity including within the NI HSC laboratory network (Pillar 1); and in overseeing operational delivery and implementation of the National Testing Programme, which was overseen by the Public Health Agency working closely where required with the Department's officials and with the Department of Health and Social Care/UK Health Security Agency. A key function of this group was also to provide expert advice which was then considered by the Department's policy leads to inform advice to the CMO and the Minister.

219. One of the key principles underpinning establishment of the contact tracing service in Northern Ireland was that the service was embedded into and working within the overall auspices of the PHA. This approach was adopted with a view to building on the expertise already within the PHA and specifically the Health Protection service in the PHA, which had established expertise in risk assessment of incidents and outbreaks, and in undertaking contact tracing as a core aspect of its usual Health Protection function.

220. In the context of a continued increase in new cases of Covid-19 in NI, to reflect on the key issues influencing provision of the contact tracing service and to provide assurances on the capacity of the contact tracing system, a Rapid Review of the contact tracing service (CTS) and its delivery model was commissioned by CMO in Autumn 2020. This Rapid Review subsequently reported on 12th October 2020.

221. The Rapid Review was underpinned by a key assumption that there would be a significant escalation in Covid-19 infections over the weeks and months ahead (from Autumn 2020) and that in order for the service to be effective, positive cases had to be contacted within 24 hours and their close contacts within 48 hours of notification to the contact tracing system. The main purpose of the Rapid Review was to support the ongoing and future delivery of the contact tracing function by looking at the elements of the CTS that had worked well, and to consider what measures were required to effect improvements in the service with a focus on more efficient and effective contact tracing processes, supported by appropriate technology and the provision of high quality management information to support oversight of the service.

222. The Rapid Review [PM/106 - INQ000137388 (DoH ref: MMcB053)] established a number of key findings which were subsequently taken forward by the PHA and the Department. Delivery of this work was supported through the appointment to the PHA of a Director with responsibility for the Covid-19 Contact Tracing Service in NI. This Director reported to the PHA CEO and also updated the Department through participation as a core member of the Test Trace and Protect Oversight Board.

223. The UK National Testing Programme was established and managed on behalf of the four UK nations by the Department of Health and Social Care, and since

October 2021, by the UK Health Security Agency. Operational delivery of the testing programme, including overseeing local implementation of the National Testing Programme, was overseen by the Public Health Agency working closely with the Department's officials. Specific policy and guidance on trace and testing was also developed for a range of sectors, including university and higher education students, school children and prisons.

224. The Department liaised with the UK Health Security Agency (formally the Department of Health and Social Care) on matters relating to the National Testing Programme and the evolving policy across Test and Trace was through its Covid-19 Response Directorate. This liaison covered a range of issues including, for example, operational delivery and testing capacity, procurement of tests, and emerging policy considerations to inform NI policy making. The Directorate also engaged with the Scottish and Welsh Governments on emerging policy considerations to inform local policy making.

225. With the agreement of the Minister a separate NI SMART programme was established by the CMO to oversee all aspects of the introduction of community testing using Lateral Flow Devices ('LFD'). The operational expansion of asymptomatic LFD testing in NI required the Department to work in close partnership with a broad range of local partners including the Department for Communities, local government, other public sector agencies, and a range of business sectors. The Department presented a paper on the expansion of asymptomatic testing to the Executive on 10 February 2021.

226. In relation to information sharing with local government in NI, CMO and CSA met with the CEOs of NI's eleven District Councils on a number of occasions. At times these were specific to Councils with high community transmission some of these were arranged by the Department and others co-ordinated by TEO to provide updates to Council CEOs. This close working relationship with Councils was invaluable in the establishment of community testing with LFDs as part of the NISmart programme and in the roll out of the vaccination programme.

Influenza (flu) Immunisation Programme

227. The annual influenza (flu) immunisation programme is a critical element of the system-wide approach for delivering robust and resilient health and care services during the winter. The influenza vaccination programme officially began on 1 October 2020. Details of the programme are provided in the Department's Wave 2 Corporate statement (paragraphs 235 to 238).

Apollo

228. Apollo is a surveillance information system used for the collection of influenza (flu) and influenza like illness (FLI) data for patient presenting to General Practice either in normal working hours or out of hours with flu like symptoms. It was procured by the PHA. The Apollo system's primary role is to allow monitoring of: the number of patients presenting with flu/flu like illness; the number of antivirals and antibiotics prescribed; and the number of people vaccinated with seasonal and pandemic flu vaccines. Following a change in the coding system used for clinical terms by healthcare professionals to describe the care and treatment given to patients, NI and other parts of the UK moved to standardise to a new coding vocabulary in 2018 which required an update to the systems. The new coding improved data consistency and accuracy, simplifying and improving the exchange of clinical information between healthcare systems.

StopCOVID NI Proximity App

229. The Department decided to launch the StopCOVID NI Proximity App as part of the NI Test, Trace Protect Strategy [PM/97 - INQ000120704 (DoH ref: PM0053)]. The Strategy included a detailed explanation of how mobile phone based Proximity Apps could assist with Contract Tracing. Detail on the Proximity App was provided in a paper to the Executive on the Options for Digital Contact Tracing [PM/107 - INQ000120718 (DoH ref: PM0124)] & [PM/108 - INQ000130398 (DoH ref: PM0287)]. The Minister notified the Executive of progress on developing an NI specific Proximity App on 11 June 2020. The Minister subsequently informed the Executive of the planned launch of the Proximity App on 20 July 2020 and provided details of the features of the App and cases to illustrate its use. [PM/109 - INQ000130399 (DoH ref: PM0288)] & [PM/110 - INQ000130400 (DoH ref: PM0289)]

230. The Department discussed the use of smartphone proximity apps with IT colleagues in NHS England, NHS Scotland and NHS Wales, as part of an informal four nations IT collaboration group. Decisions taken by the Department on technical aspects of the App, including the use of the Google/Apple based Exposure Notifications Application Programming Interface was informed by these conversations. The ultimate decision to adopt a Google/Apple based system, as opposed to the NHS England trajectory at the time to develop a custom application, was also informed by discussions at the four nations IT collaboration group.

231. When the introduction of an NI specific app was first contemplated, the Digital Co-Ordination Cell, led by the Departmental Chief Digital Information Officer, considered the adoption of the NHS England app, which was scheduled to be launched on 18 May 2020 (subject to testing on the Isle of Wight). It was initially thought that the NHS England app could have been deployed quickly in NI, with minimal development costs and delay. However, following more detailed review and analysis, a series of technical difficulties were identified in adapting it for use with NI information systems due to the significantly different technical architectures and health and social care information systems used in NI. In addition, concerns were raised by human rights and civil liberties groups over the proposed use by the NHS England app system (v1) of a central, personal data repository. The originally proposed NHS app was not compatible with the app which was developed by the Republic of Ireland; an important consideration given the international land border. The Department published an article, on its website which provided additional information on the development of the StopCovidNI Proximity App. [PM/111 - INQ000325161 (DoH ref: PM0351)]

232. The Proximity App was originally released for use by NI citizens over 18 at the end of July 2020, and was the first of its kind to be deployed in the UK and the second to be deployed globally following the go-live of the Republic of Ireland solution the month prior. It was the first globally to function as a cross jurisdictional app. Interoperability with the Republic of Ireland proximity app to exchange anonymised location and proximity information was particularly important due to the existence of the land border and regular cross border interactions. A version for those aged between 12 and 18 was released on 30 September 2020. The version of the App for those aged under 18 years included additional material to address

General Data Protection Regulation obligations concerning consent to the use of digital products.

233. An overview of the work to produce several of the digital support tools, including the StopCOVID NI Proximity App was published on the Departmental website [PM/112 - INQ000137418 (DoH ref: PM0290)].

Covid-19 Public Information Dashboard

234. The Department made decisions on the use of information and data, generated by HSC IT systems, related to the HSC response to the pandemic. On 19 April 2020 the Department announced the release of the new Covid-19 Public Information Dashboard for NI [PM/113 - INQ000130401 (DoH ref: PM0291)]. The Dashboard included region wide summary information about the volume of testing and the number of deaths reported by HSC Trusts that were associated with Covid-19.

235. In line with the Northern Ireland Civil Service policy and practice, this Dashboard was produced to the requirements of the pillars of the Code of Practice for Statistics February 2018 edition [PM/114 - INQ000273837 (DoH ref: PM4004)] in terms of trustworthiness, quality and value. The Code of Practice has since been updated in May 2022 [PM/115 - INQ000130402 (DoH ref: PM0292)]. Although the Dashboard was based on similar information published by other UK jurisdictions, the NI information included additional, useful health service data about capacity and availability. The Dashboard was produced using data collected or received into Departmental statisticians' Covid-19 Analytics and Modelling Platform (CAMP) [PM/116 - INQ000130403 (DoH ref: PM0293)], which is an information source available for internal HSC users including detail and breakdowns of information. The information in the previous PHA Daily Bulletin [PM/117 - INQ000130404 (DoH ref: PM0294)] had been used to populate a number of documents for different audiences, including: the Department's Health Gold Situation Report; and a return for summary level statistics [PM/118 - INQ000130405 (DoH ref: PM0295)] to the Department of Health and Social Care for inclusion in UK national press releases.

Information Sharing with the Republic of Ireland

236. Ministers from the NI Executive and the Republic of Ireland Government met on 14 March 2020 to discuss North-South cooperation in dealing with the pandemic. At that meeting the Ministers affirmed that:

> *"everything possible will be done in coordination and cooperation between the Irish Government and the Northern Ireland Executive and with the active involvement of the health administrations in both jurisdictions to tackle the outbreak. Protection of the lives and welfare of everyone on the island is paramount, and no effort will be spared in that regard".*

237. This affirmation was brought into effect in the form of a Memorandum of Understanding entered into on 7 April 2020 by the Departments of Health, and their respective agencies, from NI and the Republic of Ireland. The Memorandum, 'Covid-19 Response – Public Health Cooperation on an All-Ireland Basis' [PM/119 - INQ000130355 (DoH ref: PM0171)], focussed primarily on the following key areas: modelling, public health and NPI measures; common public messages; behavioural change; research; and ethics.

238. The two Departments had weekly meetings jointly chaired by the Chief Medical Officers of NI and the Republic of Ireland. The meetings were attended by the CSA from NI and DCMOs from both jurisdictions and respective subject-specific policy lead officials. Data was shared in relation to the pandemic trajectory and information concerning the policies covering international travel in relation to border health measures. At times during the pandemic high community transmission was observed in some Border Counties. This was discussed at the weekly CMO meeting and joint actions was agreed. For example in response to high case numbers in the council areas of Donegal in the Republic of Ireland and Derry and Strabane in Northern Ireland and there was joint messaging by the CMOs on the high levels of transmission in Border Counties. This was underpinned by joint work between the HSE and PHA and civic society in Northern Ireland and the Republic of Ireland

The island of Ireland as a single epidemiological unit

239. At various times, the epidemiology differed between NI and the Republic of Ireland as it did between the various parts of the UK, and indeed within regions at the

individual county level. At other times the epidemiology in NI was much closer to that of the Republic of Ireland than the rest of the UK. That the island of Ireland acted as a single epidemiological unit throughout the pandemic was recognised at an early stage and was a point made repeatedly by CMO and CSA throughout the pandemic. The SAGE comments in its paper of 12 May 2020 [PM/120 - INQ000346698 (DoH ref: PM0374)] were echoing points made by CMO and CSA at SAGE and other fora. A decision to pursue a joint Northern Ireland/Republic of Ireland response would have been a political one requiring the agreement of the NI Executive and the Republic of Ireland's Government and could be a matter to be resolved between the Republic of Ireland and the UK government. No specific policy papers were requested or prepared by the Department on such a harmonisation approach, nor does the Department understand that any such papers were developed by the Executive Office.

240. In general terms, data comparisons between NI and the rest of the UK are likely to be somewhat more reliable as data collection and flows were similar. The Department's view throughout the pandemic was that the virus proceeded largely in a similar way across the island of Ireland, with transmission higher at some points in NI and at some points in the Republic of Ireland. Given freedom of movement across the Northern Ireland/Republic of Ireland border it is unsurprising that this was the case. At times the Department was concerned at the possibility for transmission from the Republic of Ireland to NI given policy differences, and at times Republic of Ireland officials indicated that they were concerned about the reverse case.

241. Differences in testing strategy and test numbers between NI and the Republic of Ireland make comparisons of case numbers across the two jurisdictions problematic and papers have been produced on this matter, for example [PM/121 - INQ000346713 (DoH ref: PM0410)]. The Department's view is that this is an example of a flawed analysis which does not take into account differences in testing. When there is more testing, more cases will be detected. In general, testing was higher in NI than in the Republic of Ireland throughout the pandemic, and this was the case for the period included in the paper. Therefore, any analysis which relies on case numbers, but which fails to take testing differences into account is liable to give rise to misleading results.

242. The attached paper, based on genetic sequencing data, indicates a much more complex picture across the course of the pandemic which is more aligned with the Department's view at the time. Infection moved both ways, from NI to the Republic of Ireland and from the Republic of Ireland to NI, and the balance of directional flow varied at different times during the pandemic. This paper (and the Department's view at the time) does not support Northern Ireland as a major source of transmission to the Republic of Ireland during the first year of the pandemic.

243. The Memorandum of Understanding was agreed on 7 April 2020 early in the first wave and set out the main agreed areas for cooperation in response to the pandemic. It was not a substitute for extant arrangements for engagement at official and Ministerial level between respective jurisdictions. Rather the MOU provided an additional framework underpinning these arrangements. Given the demands of the pandemic response it was not possible to formally access the effectiveness of the MOU. The Department is not aware of any similar agreements between the other nations of the UK or an assessment of their effectiveness which may provide comparative analysis. Following a request by the Minister and discussions between the CMO for NI and the Republic of Ireland, the Institute of Public Health Ireland was asked to prepare and coordinate a Rapid Review assessment of the effectiveness and contribution of the NI/Republic of Ireland MOU to the strategic and operational response to the Covid-19 pandemic. This work did not progress, and the draft terms of reference were not finalised. Despite the fact that there was no formal record or assessment of the outcomes of the MoU, there was very effective cooperation, regular engagement, and continued close working relationships at official level between the two jurisdictions throughout the pandemic as set out below. The professional collaboration historically and during the pandemic between the CMOs, their respective teams and public health agencies was effective and of significant benefit during the pandemic.

244. Advice to respective Ministers to inform policy decisions in each jurisdiction was based on the trajectory of the pandemic, relevant modelling, and health service pressures in each jurisdiction at points in time. Consequently, advice and subsequent policy decisions by Ministers, for example on the use of NPIs, will have necessarily differed at various points. In addition, Ministers were considering not only the health consequences but also the wider societal and economic factors within their respective pandemic responses. These policy differences were understandably the subject of

media coverage and commentary by independent and academic colleagues and wider political commentary. At various times there was at least the potential to dilute important public health key messages and much effort was required to ensure there was public understanding of the rationale for public health advice and policy decisions in respective jurisdictions and where these differed and why.

245. The Republic of Ireland and NI are separate jurisdictions, each with an elected Government and respective Ministers accountable for policy decisions in their own jurisdiction. The Government in the Republic of Ireland had its own separate advisory structures and committees in addition to European expert advisory structures such as the European Centre for Disease Control. While there were some differences in interpretation of emergent science, data and emphasis, the advice was generally broadly consistent and the public health advice and introduction of NPIs in both jurisdictions was broadly aligned with some differences in timing and extent as determined by policy decisions. In practical terms the sharing of information and collaboration between respective CMO offices and officials in the two Departments of Health was very effective. An academic qualitative review of public health policies for Covid-19 in NI and the Republic of Ireland was undertaken during the first wave of the pandemic [PM/122 - INQ000137387 (DoH ref: MMcB052)]. This study concluded: "that notwithstanding the historical and constitutional obstacles to an all-island response to Covid-19, there is evidence of significant public health policy alignment brought about through ongoing dialogue and cooperation between the health administrations in each jurisdiction over the course of the first of the first wave of the pandemic."

246. It had been agreed in the MOU that both jurisdictions would work to undertake modelling to inform evidence based policy decisions on how best to respond across the island of Ireland. In the first wave Informal discussions were held between the CMO and his counterpart in the Republic of Ireland, and with their respective teams, on the issue of treating the island of Ireland geographically as a common epidemiological unit, for example in respect of all island modelling. This was explored, however it was acknowledged at the weekly formal meetings between CMOs and respective teams that there were real practical difficulties in terms of different approaches to testing, the comparability of data, given differences in how this data was captured, recorded and data flows this did not seem feasible. It was concluded that as an alternative the close sharing of approaches to modelling and

modelling outputs would be shared in the weekly CMO meetings as a more pragmatic approach. The agenda of the joint CMO meetings was broad and information was also shared and discussed on key policy areas such as approaches to NPIs, testing, contact tracing, and later vaccine deployment. In addition, there was detailed consideration of outbreaks with cross border potential implications, wider public health measures and the outcomes of key research studies. There was also high level discussion on the advice being provided to core decision makers from a medical and scientific perspective.

247. There were however some challenges in a few areas of the pandemic response between the two jurisdictions, for example in relation to data sharing arising from international travel. It took some time to progress the technical solution and the legal framework for the sharing of passenger details of those returning on international flights into the Republic of Ireland and then travelling on to NI. This was the subject of correspondence between respective UK Ministers, the Health Ministers in NI and the Republic of Ireland, the First Minister, the deputy First Minister, the Taoiseach and the Tánaiste. There were also some differences in relation to the respective jurisdiction's assessment of the risk associated with overseas travel from certain countries. While these issues were not straightforward to address, the CMO Group on behalf of the Department and the Executive did agree formal information on sharing arrangements. In the interim, joint approaches were established to address the issue of NI residents arriving into the Republic of Ireland before travelling on into NI. This included for example the development by officials in NI and the Republic of Ireland of a SMS system that notified those travelling across the border of the requirement to complete both passenger locator forms (PLFs). The position in relation to international travel and the assessment of relative risk was already a complicated issue to explain to the public and one that rapidly changed with each review and risk assessment at an individual country level. As such, differences in approaches in both jurisdictions added to the communication challenges and agreeing the final arrangements on data sharing took longer than was expected, although through joint working was addressed.

248. As a consequence of the pace of events and the many complex considerations involved, policy decisions in NI were often taken and implemented at short notice based on health advice and also with respect to a broader range of factors as described in paragraph 60 above. As a result, policy decisions and

changes in NI for example in respect of NPIs may not have always been communicated to the ROI in advance. Similarly, on occasion the Department and other Executive Ministers may not always have been aware of changes with respect to NPIs in the ROI in advance of these being announced.

249. At official level, historically and during the pandemic, there was very close cooperation and regular engagement and cooperation. The professional collaboration between the CMOs, their respective teams and public agencies was effective and of significant benefit during the pandemic.

250. Consistent with the MOU, there was for example, very close and effective cross border cooperation by NI and Republic of Ireland public health organisations and Departments to address high transmission rates in certain border counties. This involved joint public health messaging and evidence based intervention to affect behaviour change to reduce community transmission. In response to this it was agreed that both the PHA and the Republic of Ireland's Health Services Executive would formally meet regularly and share data and intelligence. The joint Republic of Ireland and NI collaboration in relation to border issues was exemplified by the actions taken in response to a high level of infection in the border area of Donegal and Strabane and Derry City Council area in effect treating taking a common epidemiological approach and applying evidence based public health interventions. At the request of both CMOs, respective public health agencies worked with local councils, the business community and wider civic society to ensure coordinated action to reduce community transmission; this included joint public messaging on media outlets in NI and the ROI. Following a North South Ministerial Council meeting on 25 September 2020 to discuss the growing prevalence of the virus in both jurisdictions and ongoing cooperation, the Republic of Ireland's Acting CMO and the NI CMO issued a joint statement communicating public health advice [PM/123 - INQ000276623 (DoH ref: PM2300)]. This joint approach to public health communication on an all-island basis was repeated in a further joint statement made on 15 January 2021 [PM/124 - INQ000276624 (DoH ref: PM2301)] stating concerns about the high levels of Covid-19, its impact and health service pressure urging people to follow the public health advice. This approach was further reflected in a statement on 1 April 2021 [PM/125 - INQ000276625 (DoH ref: PM2302)] following a meeting of both CMOs when they jointly appealed to the public across the island to

continue to follow public health advice over the Easter holidays (see paragraphs 156 and 157 in the Department's Wave 2 draft Corporate Statement).

SECTION G: THE HEALTH SYSTEM RESPONSE

251. During the first wave of the pandemic the Department made a number of key decisions concerning the health system's response to mitigate the impact of Covid-19 by developing and implementing counter measures. These decisions are set out below.

252. The information outlined in Section F covering the Public Health Response, informed our understanding of the potential risks to the health system in NI in the event of the extant capacity across primary, secondary and critical care, including staffing, medicines and medical devices, being outstripped by the anticipated surge in demand for services arising from the population contracting the virus in significant numbers.

253. The Department's Permanent Secretary also had a weekly meeting with the Health Service Chief Executives from England, Wales and Scotland and, for a period, a regular meeting with the Permanent Secretary for the Department of Health, Republic of Ireland. The purpose of these meetings was to share information about the trajectory of the pandemic, its impact on the demand for services, the resulting challenges and innovation in service delivery in their respective jurisdictions.

254. The CMO wrote to the HSCB's Chief Executive on 17 February 2020 [PM/126 - INQ000130370 (DoH ref: PM0206)] requesting detailed worked up integrated surge plans from community and primary care through to acute care including those areas where it was anticipated that there would be particular demands such as critical care. The HSCB Chief Executive replied to the CMO on 20 February 2020 [PM/127 - INQ000130371 (DoH ref: PM0207)] and advised that surge planning was underway and that the HSCB and PHA had established a regional operational Surge Planning Subgroup to ensure that there was an appropriate and proportionate level of HSC preparedness across the HSC in response to Covid-19.

255. On receipt of the HSCB and PHA initial surge plans the CMO commissioned further work to quality assure and address identified gaps in the initial surge plans, recognising that the lack of specificity at this time of the potential health and social

care service pressures made surge planning problematic. The quality assurance was to address gaps and to work with those involved in preparing the plans to support improvements in planning and monitoring. It was carried out by a team of assessors tasked by the Department's Chief Professional Officers to undertake a review of the social care HSC Trust Covid-19 surge planning for the Independent Care Home Sector (nursing and residential care homes) and for HSC Trusts' directly managed inpatient and residential mental health and learning disabilities services (including supported living), critical care and secondary care sectors. The gaps identified in each of the surge plans were as follows:

- Social Care - regional surge planning for the social care sector was predicated on a model of staff absence being the most significant risk factor for the continuation of services. A revised regional escalation plan set out 'a plan on a page', for care homes, mental health and learning disability sectors, with explicit expectations in respect of prevention, mitigation of risk, management of symptomatic patients and support for service continuity;

- Critical Care – the focus of this surge plan was based on a Nightingale hospital. However, there were inconsistencies in the local escalation stages before stepping up to a regional Nightingale setting which were identified and addressed in the revised escalation plan;

- Secondary Care – each HSC Trust had a plan at local level, however, testing of these identified how all HSC Trusts' plans needed to connect at a regional level to bring consistency across the region. Secondary care plans also had to connect the total system of health and social care, from critical care, community and Covid hubs, protected non-Covid services and to ensure that pathways were in place to transfer individuals across the levels of care as required.

256. The CMO also anticipated that it was likely that Health Gold would be leading the strategic policy response to the surge and giving direction to the regional coordination of the response to the surge. Therefore, to facilitate the enhanced strategic management of the surge, the CMO asked the Deputy Secretary, responsible for the Department's Healthcare Policy Group, and the Chief Nursing

Officer (CNO) to assist him with the coordination of the Department's policy input to surge planning for the health service.

257. The Deputy Secretary (Healthcare Policy Group) immediately established a Covid-19 Strategic Surge Planning Directorate to provide leadership to the Surge Policy Cell of the EOC and report into the Strategic Cell. The terms of reference for the Covid-19 Strategic Surge Planning Directorate are provided in [PM/128 - INQ000325160 (DoH ref: PM0244)]. The new Directorate was headed by a dedicated Director at Senior Civil Service Grade 5 level.

258. On 3 March 2020 the Deputy Secretary (Healthcare Policy Group) sent an email to the HSCB's Director of Commissioning to inform her that the CMO had asked him to oversee the Department's policy input and coordination to HSC surge planning covering workforce, primary and secondary care. The Deputy Secretary proposed that, as the HSCB Director of Commissioning was leading on surge planning at silver level, it would be useful to have an early meeting to scope out and agree the lines of communication and arrangements for engagement.

259. From this point the CMO, Chief Nursing Officer (CNO), Deputy Secretary (Healthcare Policy Group) and the Covid-19 Strategic Surge Planning Director worked together as a leadership group, within the Strategic Cell, to coordinate the Department's policy input to surge planning for the health service. This leadership group worked closely with the HSCB Director of Commissioning to ensure that the development of the Department's policy was responsive to the evolving situation within HSC Trusts and fully informed by expert medical advice provided by the HSCB and Public Health Agency.

260. A Surge Planning workshop was held on 5 March 2020 to consider the HSC Trust surge plans and ensure regional consistency where possible. There followed intensive engagement between the Department, HSCB, the Public Health Agency and HSC Trusts resulting in the publication on 19 March 2020 of the Health and Social Care (NI) Summary Covid-19 Plan for the period Mid-March to Mid-April 2020 [PM/129 - INQ000130410 (DoH ref: PM0300)]. The Plan summarised the key actions taken by the HSC from mid-March to mid-April 2020 to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. This was a dynamic plan, which was to be constantly refined in light of the emerging issues.

261. The Health and Social Care (NI) Summary Covid-19 Plan set out the planning assumptions available to the HSC. In a reasonable worst case scenario these planning assumptions were as follows:

> *"If we fail as a community to take action to slow down the transmission of the virus in line with the recommended public health guidance - up to 80% of the Northern Ireland population will be infected during this epidemic. Up to half of these may occur in a period of three weeks centred around the peak".*
>
> *"If social distancing and other measures are implemented by the population, with a combined effect they could reduce the peak by some 50% and reduce deaths by up to a third. Planning assumptions also indicate that 8% of infected people will require hospitalisation, 0.7% will require critical care, and 1% will die – although these figures will vary highly depending on age and other health factors".*
>
> *"Importantly, it is predicted there may be 21% health and social care staff absence during the peak weeks of an unmitigated pandemic (without social distancing and other reduction measures being implemented). An absence level such as this will require a flexible staffing policy involving current staffing levels to be augmented from areas of reduced activity, for example from theatres; some nursing care being delivered by non-ICU trained staff; and the normal nurse to patient ratios of 1:1 may be reduced".*

262. The remainder of the Plan outlined the measures to be taken between mid-March and mid-April 2020 across 21 HSC service delivery areas in order to manage the impact of Covid-19 across the community. The key decisions taken by the Department to introduce these measures are set out below in the following sub-sections.

Primary and Community Care

263. The Department's Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020, outlined the Department's response to the initial surge within Primary and Community Care.

264. In General Practice, the Department aimed to optimise the input of other members of staff such as practice based pharmacists and nurses to assist with increased pressures. Routine GP work was adjusted or suspended. This included the suspension of non-contracted work, suspension of the Quality and Outcomes Framework[8] and enhanced services as appropriate'. This action aimed to help GP practices manage the potential significantly increased demand (estimated as a 30% increase) at a time of potential reduced GP workforce. A GP telephone first consultation process enabled GP practices to determine the most appropriate approach to safely addressing the patients' needs, with face-to-face appointments arranged if clinically appropriate. It was anticipated that this would prevent many patients attending their GP surgery if it was not necessary to do so, and hence help prevent the spread of infection. GP practices were also engaged in implementing the Department's response to the pandemic in other areas of activity, particularly: in establishing and running the network of Primary Care Covid-19 Centres across NI (see paragraphs 265 to 269 below); and, in identifying and providing guidance and support to patients considered as Clinically Extremely Vulnerable (see paragraph 270 below).

Primary Care Covid-19 Centres

265. Given the rapidly changing situation regarding Covid-19 and its impact on service demand across the whole of the HSC, the Head of General Medical Services in the then Health and Social Care Board chaired a teleconference on 16 March 2020 to discuss the rapid setting-up of Primary Care Covid-19 Centres in the community. Officials from the Department and the PHA together with representatives from the Royal College of General Practitioners NI, the British Medical Association's NI General Practitioners Committee and GP Federations participated in the meeting. [PM/130 - INQ000120722 (DoH ref: PM0133)], [PM/131 - INQ000120724 (DoH ref: PM0134)]

266. The Department aimed to use these Centres to protect capacity within Primary Care by ensuring that GP services, for patients with non-Covid related conditions, could be maintained by providing dedicated separate assessment centres

[8] The Quality and Outcomes Framework (QOF) **is** a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004.

for those patients who showed Covid-19 symptoms. The Centres would provide services for patients symptomatic of Covid-19, and who were at higher risk of complications, or those described as having moderate or severe symptoms, and who required clinical assessment.

267. The Covid-19 Centres:

- provided virology testing for healthcare workers who were symptomatic or suspected of having Covid-19;
- provided clinical assessment of suspected Covid-19 patients upon referral from their GP practice or GP Out of Hours service;
- reviewed suspected Covid-19 patients, if required in the Centre or at home or elsewhere in the locality;
- provided access to Secondary Care input/protocols to help with decision making regarding the management of patients' treatment; including making the arrangements to transfer patients for inpatient care when appropriate;
- ensured that arrangements were in place for the supply of any urgently required medicines;
- provided access to Social Care for patients unable to be managed at home but who were not ill enough for admission to hospital; and,
- referred patients to Covid-19 Palliative Care resources if required.

268. On 18 March 2020, the Head of General Medical Services (HSCB), the Department's Director of Primary Care, the Chair of the NI General Practitioners Committee, and the Chair of the Royal College of General Practitioners NI, wrote to the GP Federation Chairs and Chairs of Local Medical Committees [PM/132 - INQ000120725 (DoH ref: PM0137)] and to GP Practices [PM/133 - INQ000120726 (DoH ref: PM0138)] to inform GPs of the planning and logistics required to set up the network of Primary Care Covid-19 Centres across NI.

269. Representatives from the Department of Health, the Health and Social Care Board, the NI General Practitioners Committee and the Royal College of General Practitioners NI took forward the planning for the Primary Care Covid-19 Centres, working intensively from 18 March to 25 March 2020 to establish the network with the first Centre at Altnagelvin Hospital opening on 25 March 2020. Further correspondence about the running of the Centres was issued to GPs on 24 March 2020 [PM/134 - INQ000120727 (DoH ref: PM0139)] and on 2 April 2020 [PM/135 -

INQ000120728 (DoH ref: PM0140)]. The network of Covid-19 Centres was fully up and running by Thursday 9 April 2020.

Clinically Extremely Vulnerable

270. Throughout the pandemic there was a focus on protecting the most vulnerable in our society as reflected in the introduction of "shielding" for those who were considered to be at significant increased risk, including those who were later defined and described as being in the cohort of the Clinically Extremely Vulnerable (CEV).

271. The Department played a significant role in providing public information and communications on the risks to public health, the rationale for NPIs and the benefits of these to the community, and in particular to those people who were most vulnerable to the virus. The Department's response to the pandemic in these areas contributed to our approach to providing targeted advice and guidance to those of all ages at very high risk in the community as to how they might shield themselves so as to avoid contracting the virus.

272. Work in this area was led from within the Chief Medical Officer's group. The designation of the Clinically Extremely Vulnerable categories of medical conditions, was informed by the information and advice provided via the Department's participation in the UK National Clinically Extremely Vulnerable Group. Public Health England and SAGE guidance in relation to concerns about the risk of high mortality among the clinically extremely vulnerable as a consequence of Covid-19 infection also informed the development of the Department's policy in this area.

273. Work across the four UK jurisdictions to develop guidance and specific supports for the Clinically Extremely Vulnerable proceeded at a rapid pace during March 2020. The CMO for England circulated a short briefing note for the Prime Minister in respect of shielding, and this was shared with the other UK CMOs on 15 March 2020 [PM/136 - INQ000346717 (DoH ref: PM0433)]. There were also direct communications between TEO and the cabinet office on the policy intent of having a UK wide approach to the shielding policy [PM/137 - INQ000346719 (DoH ref: PM0434)]. Work in this area was led by a combination of advisers from within the Chief Medical Officer's group and policy staff from the Primary Care Directorate. The advisers led on definitional issues, whilst the Primary Care Directorate team led on

the overall policy and operational issues, such as the issuing of advice letters (in partnership with the HSCB and HSC Trusts), and the establishment of supports for the CEV population. The work on these supports was carried out in partnership with other stakeholders such as the Department for Communities.

274. The CMO and Deputy Chief Medical Officers were fully engaged in the UK CMOs and the UK expert panel review of emerging evidence and discussions to identify those most at risk. This work also considered approaches to protect the most vulnerable including the ongoing review of the appropriateness and proportionality of these measures given the significant impact in terms of loneliness, isolation and mental health. In concert with other UK nations, the CMO advised on the recommendations in relation to "shielding and the CEV cohort". The Department's approach was informed in due course by its participation in the UK National CEV Group and consideration of SAGE guidance.

275. The definition of CEV initially used by all four jurisdictions in March 2020 was agreed by the four UK CMOs. However, it remained the case that each of the administrations could diverge from this definition if it so wished. Under the UK wide criteria General Practitioners and hospital specialists also had a degree of flexibility to include patients they judged to be at high risk in the supports provided for the CEV.

276. In the absence of specific vaccines or medical treatments, shielding advice was introduced by the Department on 25 March 2020. Letters were issued through GPs to those identified as clinically extremely vulnerable [PM/130 - INQ000130313 (DoH ref: PM0058)], [PM/131 - INQ000120706 (DoH ref: PM0059)], [PM/132 - INQ000130388 (DoH ref: PM0242)]. A letter to GPs identified a list of diseases and conditions considered to be very high risk. GPs were asked to identify those patients on their patient lists who fell into this group. Guidance was available to assist practices to search and identify patients who did so. The bulk of letters were issued on 27 March 2020 by GPs. In addition, HSC Trusts issued letters to specific patient groups who were known to them in March 2020.

277. The list of diseases or conditions considered to be very high risk and listed in the first shielding letter issued from 27 March 2020 were:

- Solid organ transplant recipients

- People with specific cancers, as follows:
    - People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer.
    - People with cancers of the blood or bone marrow such as leukemia, lymphoma or myeloma who are at any stage of treatment.
    - People having immunotherapy or other continuing antibody treatments for cancer.
    - People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors.
    - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
- People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as Severe Combined Immunodeficiency (SCID), homozygous sickle cell)
- People on immunosuppression therapies sufficient to significantly increase risk of infection.
- People who are pregnant with significant heart disease, congenital or acquired.

278. This letter advised individuals who fell into this group to 'shield' themselves by staying at home and avoiding all face-to face contact for the next 12 weeks. The letter provided information about actions to take in order to do so; how to access further information and support, including through the NI Community Helpline; advice on indoor exercise and mental health tools as well as providing general information on the pandemic response.

279. The CEV letters offered advice on staying safe and also enabled those who received the CEV letters the opportunity to access support schemes which were offered to the most vulnerable by the Department for Communities (DfC) [PM/132 - INQ000130388 (DoH ref: PM0242)].

280. During the pandemic, letters that issued to people who were identified as being Clinically Extremely Vulnerable provided a range of information and signposting to sources of advice to support those who were shielding, including

access to medicines and food deliveries, support for mental health and well-being, financial assistance and support when returning to the workplace.

281. Information and guidance for people who were CEV, and for those who were in the wider clinically vulnerable category, was also available on the NI Direct website, which was the primary course of advice and guidance for the public over the course of the pandemic and which provided signposting to sources for advice and support, including support for mental health and well-being, such as the Minding Your Head website. Information was also available via the 'Covid-19 NI' app, with an on-line version of the app also available.

282. A Northern Ireland Covid-19 Community Helpline, managed by AdviceNI, was available 7 days a week to support anyone who was feeling isolated or vulnerable, (whether or not they had received a shielding letter) and to provide support with accessing food and other essentials such as medicines. Early in the pandemic arrangements were put in place to collect and deliver medication to patients who were isolating or shielding. The Community Helpline was able to connect people to a range of practical and emotional support services, including local volunteer supported shopping and local or community food support organisations.

283. The Department for Communities (DfC) played a key role in arrangements to support communities and people during the pandemic, including food box deliveries to those who were unable to access food through online shopping, family, friends or local support networks and those who were shielding. The Department of Health worked with the Department for Communities in putting in place arrangements for priority access to online grocery shopping slots for those who were Clinically Extremely Vulnerable, in place from early May 2020 until shielding paused on 31 July 2020.

284. Tailored information and self-help guides from local mental health and well-being charities were available at the Covid-19 Virtual Wellbeing Hub, which launched in mid-June 2020. These resources were designed to help promote positive mental health and well-being both during and after the Covid-19 pandemic.

285. People living with other underlying health conditions were identified at a UK-wide level as part of a wider clinically vulnerable group. The clinically vulnerable were

not included in the shielding group but were advised to follow strict social distancing measures instead. This group included those who were:

- Aged 70 or older (regardless of medical conditions)
- Under 70 with an underlying health condition listed below (i.e. for adults this usually anyone instructed to get a flu jab as an adult each year on medical grounds):
    - Chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis
    - Chronic heart disease, such as heart failure
    - Chronic kidney disease
    - Chronic liver disease, such as hepatitis
    - Chronic neurological conditions, such as Parkinson's disease, multiple sclerosis (MS), a learning disability or cerebral palsy
    - Diabetes
    - Problems with their spleen – for example, sickle cell disease or those who had their spleen removed.
    - A weakened immune system as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets or chemotherapy
    - Being seriously overweight (a BMI of 40 or above)
    - Those who are pregnant.

286. There were subsequent changes to the definition of CEV in Northern Ireland, and all but one of these changes were agreed nationally by the four UK CMOs:

- -people with Motor Neurone Disease (added 2/4/20 – elsewhere in UK added at clinical discretion)
- people who have had a splenectomy (added 15/5/20 on advice from UK Clinical Panel for Shielded Patients to UK CMOs)
- those undergoing renal dialysis (added after 24/4/20 on advice from UK Clinical Panel for Shielded Patients to UK CMOs)
- Adults with Downs syndrome (added after 26/11/20 on advice from UK Clinical Panel for Shielded Patients to UK CMOs and
- Stage 5 chronic kidney disease (added after 26/11/20 on advice from UK Clinical Panel for Shielded Patients to UK CMOs

287. The inclusion of MND patients in the definition of MND was the only area where NI diverged from the rest of the UK in regard to the definition of the CEV

group. The decision was made by the CMO although the Minister was advised and aware of the decision, given that he received communications on the issue from political representatives. The vulnerability and risk in patients with MND would primarily relate to reduced respiratory capacity and difficulty clearing secretions. Many MND patients will require respiratory support in the course of their illness as indicated and therefore would probably have been identified by GPs for inclusion on the CEV list at their discretion. In reality the inclusion of MND in the NI definition of CEV will only have made a small difference here although it would have offered reassurance to this population. It is also important to note that NI probably issued more shielding letters per head of population than other parts of the UK, for reasons unrelated to the inclusion of MND.

288. The only other practical advantage of the inclusion of MND on the CEV list was in relation to Covid regulations[9i] made on 28 March 2020. These regulations prohibited "anyone from leaving the place where they are living without reasonable excuse. Examples of a reasonable excuse include the need to provide care or assistance to a vulnerable person, to travel for the purposes of work and to access critical public services." The inclusion of MND in the definition of CEV within the regulations meant that it was a reasonable excuse to leave home and travel to provide assistance to someone with MND.

289. People could also be identified as being at higher risk on a case by case basis where their attending clinician (General Practitioner or hospital specialist) assessed them as such based on their clinical judgement.

Pausing of Shielding

290. In a statement published on the Department's website on 18 May 2020, the Minister for Health advised that guidance on shielding was being actively reviewed and would be updated before the end of the 12-week shielding period. Recognising

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[9] The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 – Schedule 1.
Regulations made 9.15pm on 28 March 2020
Commencement at 11pm on 28 March 2020

how difficult shielding was, people were assured that it would last no longer than deemed clinically necessary [PM/141 - INQ000348685 (DoH ref: PM6124)].

291. The Chief Medical Officer wrote to those who were Clinically Extremely Vulnerable in early June 2020. The letter advised those who were shielding that, whilst Covid-19 still posed a high risk to those who are most vulnerable, as infection levels were falling, so the risk of exposure was significantly less. Accordingly, the guidance for Northern Ireland was updated so that from 8 June 2020, those who were shielding could spend time outside with people from their own household or one person from another household, whilst ensuring social distancing was observed. This updated shielding guidance would be in place until 30 June 2020 [PM/142 - INQ000348686 (DoH ref: PM6125)]. In a submission [PM/143 - INQ000346714 (DoH ref: PM0429)] to minister dated 16 June 2020 the Director of Primary Care advised the Minister of plans in England to pause shielding from 31 July 2020. The submission recommended that NI should follow suit. The submission incorporated evidence about the concerns of the shielded population identified in PCC research and the advice of the CMO which was that "the rate of community transmission is such that it would be appropriate to pause the shielding advice here for all adults and children on 31 July." The decision to pause shielding required Executive approval and the submission included a draft Executive paper to this end. The paper [PM/144 - INQ000346715 (DoH ref: PM0430)] was submitted to the Executive meeting held on 18 June 2020. The paper highlighted a need for some continued support beyond 31 July 2020, with helpline services to continue for the foreseeable future. HSCT support services also continued and the Department reemphasised the package of mental health support resources which had been made available online. GP or hospital specialist consultations remained available to everyone who had continuing concerns about their health. The minutes from the Executive meeting of 18 June 2020 [PM/145 - INQ000348692 (DoH ref: PM6131)] record that the Executive agreed to pause shielding from 31 July 2020.

292. In a statement made on 18 June 2020, the Minister of Health announced plans to pause the shielding advice from 31 July 2020, subject to the rate of community transmission continuing to be low [PM/146 - INQ000348687 (DoH ref: PM6126)]. A further statement issued by the Minister on 22 June 2020, announced fresh easements to the shielding advice. That statement advised that from 6 July 2020, subject to the rate of community transmission remaining low, people who were shielding would be able to meet up to six people outside the home, as long as social

distancing was strictly observed. People who were shielding and living alone would be able to form a support bubble from 6 July 2020 with one other household [PM/147 - INQ000348688 (DoH ref: PM6127)].

293. Following on from the Minister's statement, a letter from the Chief Medical Officer was issued to those who were shielding, setting out the easements to the shielding advice from 6 July 2020. The letter also advised that, if the risk continued to remain low, from 31 July 2020, those who were shielding would no longer need to follow the current shielding advice and shielding would be paused. The letter set out details about what would happen after 31 July 2020 for those who were Clinically Extremely Vulnerable and the importance of continuing to stringently follow public health advice. It also provided information and advice about support that was available to those who were Clinically Extremely Vulnerable, including information on medicines delivery, access to priority online shopping slots until 31 July 2020, advice on returning to the workplace, information on access to benefits and support for mental health and well-being [PM/148 - INQ000348689 (DoH ref: PM6128)].

294. Due to the declining pandemic during the first wave, there were easements to shielding advice from 6 July 2020 to allow for meetings of up to 6 people outdoors and to form a support bubble with one other household. By 27 July 2020 there had been no recorded Covid-19 related deaths in NI for 14 days and, considering the small number of cases and absence of deaths it was decided that advice on shielding was no longer proportionate to the risks and could be replaced by advice to take extra precautions and to follow public health advice. A statement from the Chief Medical Officer published on the Department's website, to coincide with the pause of shielding reiterated the importance of continuing to exercise caution and to follow public health advice [PM/149 - INQ000348693 (DoH ref: PM6132)].

295. Given the recognized adverse impact of "shielding" on those affected, the CMO commissioned the Patient and Client Council to undertake research into the views and needs of the Clinically Extremely Vulnerable population. The survey was carried out in July 2020 and more information on this survey is provided at paragraph 297 below. The Department sought to incorporate the findings of the survey into further advice and guidance. While no further surveys were undertaken, the research, which had been undertaken by the Patient and Client Council, was a regular factor in influencing the Department's thinking in relation to the Clinically Extremely Vulnerable population including decisions on pausing shielding and the

updating of guidance for the Clinically Extremely Vulnerable population for example at Christmas 2020 (see paragraph 247 in the Department's Wave 2 statement).

296. On 27 May 2020 the CMO emailed the Chief Executive of the Patient and Client Council asking that the council undertake research to "inform the relaxation of some of the current restrictions around outdoor exercise and possible subsequently meeting family outdoors in small numbers with appropriate safeguards and precautions." [PM/150 - INQ000346716 (DoH ref: PM0432)] The email indicated that the proposed research was supported by the Minister and by FM/dFM.

297. The Minister for Health published a statement encouraging people who were Clinically Extremely Vulnerable, and those supporting them, to participate in the survey, the aim of which was to understand the impact shielding had on individuals, to inform the steps and processes that must be considered then and in the future, and to ensure that the voice of those impacted by shielding was heard [PM/151 - INQ000348703 (DoH ref: PM6143)].

298. The Chief Medical Officer's letter, which issued in early June 2020 to advise of a change in shielding advice, also advised recipients that the CMO was leading a programme of rapid engagement with people who were shielding so that, in considering the future of shielding, there would be a clear understanding of the issues those who were shielding faced. The letter provided details on how to participate in the PCC survey online, by post and by telephone. The final PCC survey report was published in July 2020 [PM/152 - INQ000353602 (DoH ref: PM0424)].

299. The findings of the survey [PM/153 - INQ000344088 (DoH ref: PM0060)] indicated that fear of Covid-19, and the risk it represented, was the dominant concern among those surveyed. In addition, shielding appeared to have had detrimental social and psychological effects on a significant group of respondents, although relatively very few of those surveyed mentioned a need for professional support or counselling. Those who were shielding prioritised being kept informed with clear advice and guidance, along with the scientific rationale for this advice. A considerable number of respondents felt that the shielding community was often 'forgotten' or 'ignored' as changes to guidance and restrictions for the wider population were announced.

General Dentistry and Ophthalmic Services

300. The Department's Acting Chief Dental Officer provided advice to the Minister regarding the impact of Covid-19 on dental services. He liaised with his counterparts in England, Wales and Scotland to ensure that decision making was broadly consistent across the UK regarding dentistry provision and risk assessment. The Department's Healthcare Policy Group worked with the Health and Social Care Board to develop and implement a Coronavirus Financial Support Scheme for General Dental Practitioners. The scheme covered the unavoidable costs of providing dental care on behalf of the Health & Social Care sector. Additional funding was also provided to both dental and ophthalmic services during the pandemic.

301. With effect from 23 March 2020 all aerosol generating procedures within dentistry were suspended and the service moved to urgent dental care provision only. On 3 April 2020 Out of Hours dental clinics ceased operation and on 4 April 2020 urgent dental care centres were opened by the five HSC Trusts to provide additional capacity. With effect from 24 March 2020 all routine General Ophthalmic Services were suspended, with only essential and urgent eyecare services continuing. Domiciliary eyecare services were also suspended.

302. Departmental officials consulted on an ongoing basis with the British Dental Association throughout the first wave on measures introduced to protect dental services. The Minister met with representatives of the Association on 2 July 2020 [PM/154 - INQ000120707 (DoH ref: PM0061)] to address some of the concerns raised by the Association, on behalf of its members, in relation to the supply of PPE, financial support for General Dental Services and ensuring that dental and oral health featured as a priority in the Rebuilding of HSC services.

303. The Department's Acting Chief Dental Officer liaised with their counterparts in England, Wales and Scotland on an informal basis. Decision making was broadly consistent across the UK regarding dentistry provision, risk assessment and guidance. The Acting Chief Dental Officer also had informal discussions with their counterparts in the Republic of Ireland regarding the Covid-19 risks specific to dentistry. E-mail exchanges also took place with the Chief Dental Officers from Australia, Canada, New Zealand and the USA to share guidance documents for dental services.

304. From April 2020, the Health and Social Care Board Head of Ophthalmic Services liaised with Chief Optometric Advisers from Scotland and Wales on a weekly basis to ensure that decision-making was broadly consistent. These meetings included representatives from General Optical Council (regulator) and College of Optometrists (professional body) to assist in both formulation of advice, and ensure consistency of approach, with regards to risk assessment and guidance.

Medicines and Community Pharmacy

305. The Department's Chief Pharmaceutical Officer liaised with the Department of Health and Social Care, the Medicines and Healthcare Regulatory Agency and counterparts in Scotland and Wales to ensure that there was a UK wide approach to the use of medicines and vaccines during the pandemic. The sharing of information between the four countries also helped inform local decisions in NI relating to the deployment of countermeasures including vaccines and antivirals.

306. Departmental officials attended UK four country meetings led by the Department of Health and Social Care relating to managing and distributing priority medicines, including supportive medicines, treatments, vaccines and clinical trials, and global supply chain risks. There was also a four nations weekly call on medicines supply and Covid-19. From April to July 2020 the Department participated in a Remdesivir Covid-19 Access and Policy Group which dealt with managing procurement, distribution, and supply of remdesivir to the UK four nations. A Stockpiling project oversight group met fortnightly from June to October 2020 and a Medicines Supply Strategic Advisory Board also met fortnightly from July 2020. There was also ongoing liaison between the Department and the Medicines and Healthcare Products Regulatory Agency on a range of issues relating to the deployment of Covid-19 countermeasures in NI. The issues covered included advice on marketing authorisations, distribution models and storage of vaccines.

307. The Department's liaison with the above UK groups helped to ensure that there was a UK-wide approach to the use of medicines and vaccines. The sharing of information between the four countries also helped inform local decisions in NI relating to the deployment of countermeasures including vaccines and antivirals.

308. The Chief Pharmaceutical Officer issued a public information notice on 14 March 2020 [PM/155 - INQ000120720 (DoH ref: PM0131)] to reassure the public that

the Department was working to ensure that everyone continued to have access to their local community pharmacy, and there were no prescription medicine shortages as a result of Covid-19. The public was asked to avoid stockpiling or purchasing unnecessary medication as this could disadvantage other patients. At this time significant work had been undertaken by DHSC on behalf of the four UK countries on a multi-layered approach to bolster medical supply chains which included holding more medicines within the UK. Local contingencies were also in place within HSC Trusts' to assure supplies of medicines, medical devices and medical consumables supply chains in Northern Ireland.

309. The Chief Pharmaceutical Officer issued a further public information notice on 18 March 2020 [PM/156 - INQ000120729 (DoH ref: PM0141)] informing the public about changes to the Community Pharmacy service arrangements in line with government guidance on social distancing, which was designed to keep both staff and the public safe. The Chief Pharmaceutical Officer again reassured the public that there was no shortage of medicines in the supply chain. This was followed by a further news release for Community Pharmacies on 29 March 2020 [PM/157 - INQ000103651 (DoH ref: PM0062)] to provide guidance on maintaining business following concerns about the impact of the statutory restrictions regulations, covering social distancing, on Community Pharmacies.

310. The Department provided additional funding to Community Pharmacies to ensure that they could continue to maintain the supply of essential medicines during the initial stages of the pandemic and to provide additional services from July 2020 to meet the needs of patients. From April 2020 the Department also established a volunteer-led service to deliver medicines to patients who were self-isolating or unable to leave their home because of Covid-19.

Population Screening Programmes

311. In consultation with the HSCB, in mid- March 2020 the PHA produced proposals in relation to the population screening programmes, in the context of the emerging Covid-19 outbreak in NI. The PHA proposals were to pause most screening programmes for a defined period (3 months initially) to release staff to undertake other duties related to the Covid-19 surge, but to complete screening investigations and ongoing surveillance monitoring for those who were under investigation for a potentially adverse screening result at that time. A paper on the

risk assessment undertaken by the PHA for each screening programme was shared with HSC gold in mid-March 2020 [PM/158 - INQ000346699 (DoH ref: PM0375)]. Proposals [PM/158 - INQ000120730 (DoH ref: PM0142)] on the temporary cessation of population screening programmes were submitted to the Minister for consideration and decision, relating to the four broad categories of screening programmes: cancer screening; non-cancer screening; and antenatal and new-born screening programmes. The Minister agreed to pause certain screening programmes while maintaining those that are time critical and/or focussed on high-risk occupations. In the context of the emergency phase of the response to the pandemic there was no statistical modelling of the impact of pausing of screening programmes. The Department subsequently announced on 7 April 2020 that routine screening programmes[10] had been temporarily paused to allow staff and resources to be reallocated to tackling Covid-19. The pause in screening was also intended to minimise risk to those people who attend screening programmes, in a higher-risk category from potentially contracting coronavirus, through maintaining social distancing.

Services Provided within Acute Hospital Settings

312. The Department's Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020, published on 19 March 2020, outlined the planning assumptions available to the HSC in a reasonable worst case scenario and of the actions taken across the HSC system to prepare for the impact of Covid-19. The actions in the Plan aimed to ensure that there would be sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period.

313. On 26 March the Permanent Secretary for Health wrote to the Chief Executives of HSC Trusts [PM/160 - INQ000325159 (DoH ref: PM0147)], on the

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[10] Programmes affected were routine cervical cancer screening; routine breast cancer screening; bowel cancer screening; abdominal aortic aneurysm (AAA) screening and surveillance monitoring; and routine diabetic eye screening and surveillance monitoring. Screening continued to be offered for people who require higher risk breast screening; diabetic eye screening for pregnant women; new-born bloodspot screening; new-born hearing screening (this programme focused on completing screening prior to discharge from maternity units only); antenatal infections screening; and smear tests for non-routine cervical screening (e.g., repeat tests requested by colposcopy or the laboratory).

issue of "COVID-19: Preparations for Surge". That correspondence included a range of actions that Trusts were asked to take to maximise surge capacity in hospitals, including that "it will be more important than ever for Trusts to implement effective discharge arrangements for patients as soon as they are well enough to leave hospital in order to release beds for newly admitted patients. Trusts should also work to maximise and utilise all spare capacity in residential, nursing, and domiciliary care." This request was aligned with approaches which were being taken across other parts of the UK at that time, as all healthcare systems were activating surge plans in anticipation of potentially high COVID admissions during the first wave. This involved a range of measures to maximise capacity in hospitals, including through effective discharge arrangements.

314. Effective discharge of patients in line with their healthcare needs was an important part of NI surge plans from the early stages of the pandemic response. The use of spare capacity in nursing homes represented one of a range of possible discharge arrangements, which also included discharge to the patient's own home or to residential or domiciliary care facilities.

315. Inpatient capacity was increased in designated wards that could treat up to 280 adult inpatients with Covid-19. All HSC Trusts assessed the steps required to convert additional wards currently used by medical and surgical specialties into areas to treat patients diagnosed with Covid-19. If required, it was anticipated that the normal capacity of 88 critical care beds across the HSC could be increased by a further 38 beds. Mechanical ventilators had been ordered to increase the then current stock of 139 to 179 by end-March 2020. The Department worked closely with NHS partners on a four nations basis to ensure adequate supply of ventilators as required.

316. On 26 March 2020 the Department's Permanent Secretary sent a letter [PM/160 - INQ000325159 (DoH ref: PM0147)] to all HSC staff setting out the next phase of emergency planning for the initial surge in demand during the first wave of the pandemic. The letter summarised the extensive planning and investment underway across the HSC system designed to increase capacity. The Permanent Secretary gave encouragement to his colleagues stating that:

> *"ensuring that we can meet these pressures as best we can, will require a collaborative approach, streamlining processes and decision making to put*

the interests of our patients and staff first. Together we must look after each other's wellbeing to ensure that no-one is left behind or feels neglected during the turbulent times which we are now living through".

317. On 1 April 2020 the Department announced [PM/161 - INQ000103652 (DoH ref: PM0063)] the key consensus estimates of the NI modelling group, based on outputs from several different models, which informed intensive hospital planning for the forthcoming surge in Covid-19 cases. The modelling outcome set out a reasonable worst case scenario, based on a number of assumptions including social distancing measures producing a 66% reduction in contacts outside the home and workplace. In addition, it was anticipated that 70% of symptomatic cases would adhere to self-isolation. The modelling team's[11] best judgement was that this would lead to a peak number of 180 Covid-19 patients requiring ventilation and critical care beds during the first wave of the pandemic. The modelling assessed that the peak number of Covid-19 hospital admissions would be 500 per week. Under this reasonable worst case scenario, the projected number of cumulative Covid-19 deaths in Northern Ireland over 20 weeks of the epidemic was calculated to be in or about 3,000. The modelling indicated that the peak of the first wave of the epidemic was expected to occur between 6-20 April 2020.

318. Informed by the reasonable worst case scenario modelling, the Department initiated a rapid assessment of potential sites, external to the HSC, on which to locate a Nightingale Hospital facility to provide additional critical care beds if needed. This assessment was supported by officials from Health Estates (Department of Finance), representatives of the Northern Ireland Critical Care Network, a nursing adviser and the Military. This work included assessing the Titanic Exhibition Centre, Belfast Harbour Studios, and the Eikon Exhibition Centre at Balmoral Park, Maze, Co. Antrim as potential sites.

319. The Department had the ability to activate the UK protocol requesting Military Aid to the Civil Authority (MACA). The MACA UK protocol was published on the 4

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[11] The modelling team authors emphasise that the work is not a prediction or forecast, rather a model for planning purposes; and also, state: "It is assumed that current restrictions remain in place for the foreseeable future. When the current restrictions are relaxed, there will be a second wave. Future modelling will focus on the size and shape of this depending on how/when restrictions are relaxed or re-introduced. This will remain the case until there is substantial population immunity either as a result of recovery from infection or successful vaccination."

August 2016 [PM/162 - INQ000390021 (DoH ref: PM0149)]. At the initial stages of the pandemic the Department's Emergency Operations Centre assisted with the coordinated transfer of Covid-19 patients to specialist hospitals in England for extra-corporeal membrane oxygenation (a time-critical therapy for advanced respiratory failure that is by definition a risk to life). This involved liaison with the Northern Ireland Office and the Ministry of Defence for transfer of these patients by Military transport. The Department also coordinated the transfer of non-Covid seriously ill patients from NI for treatment in specialist hospitals outside the jurisdiction as required. This coordination role transferred from the Emergency Operations Centre to Policy Cells as the pandemic evolved.

320. During April 2020 the Minister also approved two decisions to request assistance from Military Assessment Teams. The first decision related to the need to redistribute medical equipment between hospitals across NI to ensure that all hospitals had the necessary equipment including ventilators required to fully enact their surge plans. The second decision related to the provision of technical advice and assistance to explore the potential for the development of the proposed temporary Nightingale Hospital facility.

321. In parallel to the assessment of these external sites for a Nightingale Hospital facility, assessments of options for reconfiguring HSC hospital sites to increase critical care capacity were also underway.

322. Following the assessment of the external sites and discussions with the clinical lead of the Critical Care Network and the Chief Executive of the Belfast Trust, the Belfast City Hospital's tower block emerged as the preferred site for locating Northern Ireland's first Nightingale Hospital for the anticipated surge of Covid-19 patients requiring intensive care in the weeks ahead.

323. While the Eikon Exhibition Centre offered the optimum potential for a Nightingale Hospital facility on an external site, the Belfast City Hospital Tower Block could be more quickly adapted than the Eikon Centre. This factor swayed the decision in favour of the Belfast City Hospital Tower Block, to provide a 230 bed regional facility staffed by a medical and nursing team drawn from across Northern Ireland. The Department obtained the agreement of the chief executives of the HSCB, PHA and HSC Trusts for use of the preferred site.

324. The Minister agreed the Department's recommendation to designate Belfast City Hospital's tower block as Northern Ireland's first Nightingale Hospital for the anticipated surge of Covid-19 patients requiring intensive care in the weeks ahead. This decision was announced on 2 April 2020 [PM/163 - INQ000103653 (DoH ref: PM0064)]. Surge plans also included the development of further critical care capacity at Altnagelvin and Ulster Hospital sites as part of a phased approach to the surge plan. Establishing this Nightingale facility would require significant temporary reconfiguration of existing critical care provision across the HSC hospital network. The Chief Pharmaceutical Officer also worked with BOC Limited to ensure suitable oxygen supply to all sites providing critical care.

325. During March and April 2020 critical care units across NI implemented the Regional Critical Care Surge Plan [PM/164 - INQ000103654 (DoH ref: PM0065)], [PM/165 - INQ000103657 (DoH ref: PM0066)], [PM/166 - INQ000103658 (DoH ref: PM0067)], providing the capability for the system to significantly increase critical care capacity to 198 level 3 beds, which was close to three times the normal capacity. This escalation in capacity involved significant staff redeployment and reconfiguration of clinical space in hospitals. The CNO led the nursing care response and worked closely with HSC Trusts' Directors of Nursing and the Critical Care Network to agree staff training, redeployment, skill mix and patient care ratios. On 13 May 2020 the Department announced that it had reduced the escalation level for critical care to 'Low Surge' and that the Nightingale hospital would therefore be temporarily stood down as it had not been required to deliver its full capacity during the first wave due to the commitment of HSC staff across the network and the positive impact of social distancing.

Guidance on Visiting Hospitals

326. The Department issued a statement on 12 March 2020 [PM/167 - INQ000103659 (DoH ref: PM0068)] alerting the public that HSC services were under growing pressure due to the increase in cases of coronavirus. The Department expected that normal business would not be possible as the HSC moved into the next phase of the pandemic. Whilst a blanket ban on visits was not introduced, the statement set out guidelines for visitors to help ensure the safety and wellbeing of patients and staff.

327. On 27 March 2020, the Department issued advice to the HSC Trusts [PM/168 - INQ000103660 (DoH ref: PM0069)], [PM/169 - INQ000103663 (DoH ref: PM0070)], [PM/170 - INQ000103664 (DoH ref: PM0071)] to inform them that with immediate effect, based on clinical advice, visits to hospitals were to be stopped in the interests of protecting patients, their families and HSC staff. There were limited exceptions to this, in that (1) Restricted visiting was permitted to patients receiving palliative / end of life care. Patients in ICU and other high dependency settings could also receive some limited visits, (2) while visiting was not permitted in ante-natal or post-natal ward areas in Maternity Service settings, women in established labour could be accompanied by one birthing partner through the birthing process, and (3) children admitted to Paediatrics settings, including Neonatology/Paediatric ICU could be accompanied by a parent. This approach to facilitating limited visiting was subject to ongoing review, and on 9 April 2020, updated guidance [PM/171 - INQ000353609 (DoH ref: PM0438)] was issued which stopped face-to-face visits in ICUs, recommending that where possible virtual visits be facilitated in those settings.

328. Further guidance for specific settings/patients was developed and issued over the subsequent period culminating in the Minister announcing [PM/172 - INQ000103666 (DoH ref: PM0073)] changes to restrictions on visiting across all care settings on 30 June 2020. The COVID-19: Regional Principals for Visiting in Care Settings in Northern Ireland [PM/173 - INQ000103667 (DoH ref: PM0074)] took effect from 7 July 2020. This revised guidance recognised the right of people to visit their loved ones in hospitals and Care Homes, while balancing the ongoing risk from Covid-19.

HSC Workforce

329. The numbers of beds described in paragraph 325 above assumed availability of a full complement of specialist staff. It was predicted that health and social care staff absence could be as high as 21% during the peak weeks of an unmitigated pandemic. An absence level such as this would require staff to be flexible and to be prepared to work wherever they were needed the most. However, by 14 May 2020 the HSC had tested 13,025 health care workers which contributed to the relatively low staff absence rate.

330. The testing of health care workers identified asymptomatic infection protecting patients primarily but also reducing the risk of staff to staff transmission in the workplace causing significant workplace outbreaks.

331. Although there was a relatively low level of staff absence, the anticipated surge in demand for critical care resulted in the redeployment of elective care staff to support critical care in hospitals. Training and enhanced supervision arrangements were provided for the redeployed staff. Certain third year nursing and midwifery students as well as final year medical students were also provided with options to join the workforce early, in order to assist clinical teams across HSC [PM/174 - INQ000137419 (DoH ref: PM0305)].

332. On the 20 March 2020 the Department published [PM/175 - INQ000103668 (DoH ref: PM0075)] an initiative to recruit former health professionals back into the health and social care workforce via the HSC Workforce Appeal. It was anticipated that this initiative had the potential to add over 5,000 temporary staff to the HSC workforce. The initiative was supported by the General Medical Council, the Health and Care Professions Council, the Northern Ireland Social Care Council and the Nursing and Midwifery Council.

333. On 24 March 2020 the Minister announced [PM/176 - INQ000103669 (DoH ref: PM0076)] that he had secured financial support to reimburse car parking charges to health and social care staff. This acknowledged the hard work and long antisocial hours that staff were working.

334. On 16 April 2020 the Department launched 'Covid-19 A Framework for Leaders and Managers' [PM/177 - INQ000120708 (DoH ref: PM0078)], [PM/178 - INQ000353599 (DoH ref: PM0411)], which was a document setting out a range of practical measures to protect the psychological health and wellbeing of HSC staff and volunteers during the pandemic. The Framework is based on evidence and best practice guidance and is informed by The British Psychological Society Guidance Paper [PM/179 - INQ000390023 (DoH ref: PM0080)]. A Staff Wellbeing Working Group was established to oversee service delivery and to review the implementation of the Framework.

335. The CNO met regularly with the Chief Nursing Officers from England, Scotland, Wales and the Republic of Ireland, initially alongside the Nursing and

Midwifery Council, to discuss workforce and regulation issues. The CNO continued to meet with her counterparts to discuss a wider range of nursing issues.

Cancellation or Postponement of Elective Care

336. The redeployment of elective care staff to support critical care resulted in the cancellation or postponement of non-urgent appointments, investigation and procedures across outpatients, day case, impatient and diagnostic services, except for the treatment of cancer and other urgent procedures. To help increase elective care capacity the Minister, in his opening Statement [PM/180 - INQ000130411 (DoH ref: PM0301)] to the Assembly's Ad Hoc Committee meeting on 15 April 2020, informed members that HSC Trusts were accessing the independent sector hospitals to treat urgent, non-Covid 19 patients across a number of elective specialities. It was expected that 120 to 135 procedures would be carried out per week across a range of red flag and urgent cases. The HSC funded this activity on the basis of compensating the independent sector on a net cost recovery, not for profit basis.

Children's and Maternity Services

337. On 3 April 2020 the Department announced plans [PM/181 - INQ000130412 (DoH ref: PM0302)] to protect Children's and Maternity Services as a further element of planning for the expected surge in increasing numbers of Covid-19 patients. The plans complemented the critical care surge plan to establish the Belfast City Hospital Tower Block as Northern Ireland's first Nightingale Hospital, by releasing bed space to contribute to the overall surge response. The plans were designed to protect children's services to ensure that babies and children who needed urgent or emergency care were able to get that care from suitably qualified and experienced paediatric staff in a timely way.

SECTION H: PERSONAL PROTECTIVE EQUIPMENT (PPE)

338. In NI the Business Services Organisation's Procurement and Logistics Service (BSO PaLS) is responsible for NI's HSC equipment supply chain and procurement activity on behalf of HSC Trusts. As part of the UK Pandemic Influenza Preparedness Programme (PIPP), the Department's Emergency Planning Branch manages PIPP stockpiles for use in an emergency, which act as a buffer to the HSC normal supply chain. These stockpiles include medicines such as antivirals and

antibiotics as well as clinical consumables and PPE including gloves, aprons, gowns, facemasks, visors and eye protection. During the initial response to the pandemic, the four UK countries worked closely together regarding management of PIPP stock, with Public Health England leading on 'Just in Time' contract negotiations.

339. There was a significant and intensified demand for Personal Protective Equipment (PPE) across all HSC settings at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a ban on the export of PPE by China, a leading global provider.

340. Given the critical need for PPE, a decision was taken on 23 March 2020 to establish a distinct PPE Strategic Supply Cell. The aim of the PPE Strategic Supply Cell was to prioritise the supply and distribution of PPE for the HSC and improve the robustness of the decision-making at the appropriate level. The Emergency Planning Branch retained overall responsibility for the release of Pandemic Influenza Preparedness Programme (PIPP) stocks throughout the pandemic.

341. At that time issues were being escalated to the Department around the supply and availability of PPE, both within HSC Trusts, but also within parts of the HSC which would normally not use PPE daily, for example, Community Pharmacies or those who would normally source their own supplies, such as GP practices and dentists and the Independent Sector (Care Homes).

342. Concerns were also being raised around the number of staff failing the fit-testing of masks due to the range of products being supplied [PM/182 - INQ000120710 (DoH ref: PM0081)]. An audit review of fit testing for respiratory masks was carried out on a precautionary basis across the HSC system after it emerged that an independent contractor had inadvertently applied on some occasions a fit-testing setting not normally used in Northern Ireland. To ensure learning from this incident, the Public Health Agency was asked by the Department of Health to undertake a Serious Adverse Incident review and implement the recommendations.

343. The approach taken to address the issues raised, particularly around supply, was to explore every viable channel both locally and internationally to procure PPE.

344. A focus was also placed on maximising the opportunities to strengthen the local supply position and the repurposing of local manufacturing which was investigated with Invest Northern Ireland (the investment and trade arm of the Department for the Economy) and which supported engagement with businesses in this area.

345. Whilst the HSC procurement lead, the Business Services Organisation, had ultimate responsibility for procuring PPE, their efforts were strongly supported by the PPE Strategic Supply Cell and the Construction and Procurement Delivery Division of the Department of Finance (responsible for leading on the procurement of PPE for the non-health sector.)

346. The three parties engaged on a near daily basis during this period to ensure efforts were co-ordinated and that opportunities were explored to source PPE locally and internationally.

347. Given the significant volume of approaches to government by potential manufacturers to supply PPE, a process was put in place in early April 2020 where all offers of help were channelled through the Department of Finance, which undertook a first level triage before directing suitable offers to the Business Services Organisation or elsewhere as appropriate.

348. The Department, the Department of Finance and the Business Services Organisation also worked in collaboration with The Executive Office to successfully purchase significant stock direct from China through a company which was identified by the NI Bureau and Invest NI in China and who had been approved by the Chinese government to export PPE.

349. Successful procurement supported by a Due Diligence Report conducted by PWC resulted in an order which was worth approximately £61 million and consisted mainly of Type IIR surgical masks and examination gloves. Copies of the contractual documentation are available upon request.

350. In addition, opportunities for joint endeavours with the Republic of Ireland were explored but ultimately did not materialise. In mid-March/early April 2020 a joint order for PPE was taken forward by the Department of Finance and the Department of Health in NI and the Department of Health in the Republic of Ireland, facilitated

through the Republic of Ireland's Industrial Development Authority. However, given the changing market conditions at that time in China and the competing demands of other countries, this became increasingly difficult and consequently the Republic of Ireland's Industrial Development Authority confirmed that they had no further capacity to pursue the collaborative order.

351. At a UK level, there was engagement with the other jurisdictions through a range of fora. The Department worked closely with them on all aspects of the UK-wide PPE Action Plan which was published on 10 April 2020 [PM/183 - INQ000145665 (DoH ref: PM0082)]. The plan was set around three strands; guidance, distribution and future supply, which was aimed at ensuring that everyone got the PPE they needed. This engagement allowed for a collaborative working arrangement which included the application of mutual aid, whilst enabling each nation to continue with its own procurement plans.

352. In addition to pursuing all potential supply avenues, efforts were focussed on putting in place the processes which would, *inter alia* identify issues pertaining to confidence in supply at an early stage; support the management of demand in HSC Trusts to ensure a more even distribution of stock across all HSC sites [PM/184 - INQ000120711 (DoH ref: PM0083)]; enable provision of PPE to the Independent Sector by their local HSC Trust; and assess the level of immediate and forecasted demand.

PPE Stock

353. To inform the demand for PPE, initial modelling was undertaken by the HSCB in late March 2020. The modelling looked at PPE demand across hospital, community and primary care settings at extreme surge / worst case scenario. [PM/185 - INQ000130316 (DoH ref: PM0084)], [PM/186 - INQ000120794 (DoH ref: PM0248)], [PM/187 - INQ000120795 (DoH ref: PM0249)], PM/188 - INQ000120796 (DoH ref: PM0250)]

354. Whilst the Business Services Organisation utilised this information in conjunction with revised guidance on PPE requirements published in April 2020, to develop demand planning based on envisaged usage, there was a recognised need for a more dynamic approach. Led by the PHA, work was progressed on the

development of a Health Resource Demand Model, which was aimed at predicting and managing key resources, including the production of regional PPE demand estimates which were then used to inform Business Services Organisation's procurement strategy. [PM/189 - INQ000130319 (DoH ref: PM0085)], [PM/190 - INQ000120797 (DoH ref: PM0251)], [PM/191 - INQ000120798 (DoH ref: PM0252)], [PM/192 - INQ000130391 (DoH ref: PM0253)], [PM/193 - INQ000120799 (DoH ref: PM0254)], [PM/194 - INQ000120800 (DoH ref: PM0255)], [PM/195 - INQ000120801 (DoH ref: PM0256)], [PM/196 - INQ000120802 (DoH ref: PM0257)], [PM/197 - INQ000120803 (DoH ref: PM0258)], [PM/198 - INQ000120804 (DoH ref: PM0260)], [PM/199 - INQ000120805 (DoH ref: PM0261)], [PM/200 - INQ000120806 (DoH ref: PM0262)], [PM/201 - INQ000120807 (DoH ref: PM0263)], [PM/202 - INQ000120808 (DoH ref: PM0264)], [PM/203 - INQ000120809 (DoH ref: PM0265)], [PM/204 - INQ000120810 (DoH ref: PM0266)], [PM/205 - INQ000120811 (DoH ref: PM0267)], [PM/206- INQ000120812 (DoH ref: PM0268)]

Review of PPE

355. On 15 April 2020 the Minister commissioned [PM/207 - INQ000120712 (DoH ref: PM0086)], [PM/208 - INQ000120813 (DoH ref: PM0269)], [PM/209 - INQ000120814 (DoH ref: PM0270)] a rapid review of PPE to focus on the appropriate receipt, storage, distribution, and use of PPE across the HSC system. The terms of reference for the Rapid Review included an assessment of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19.

356. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the HSC system The final report was submitted to the Minister on 14 May 2020 [PM/210 - INQ000130338 (DoH ref: PM0087)], [PM/211 - INQ000120815 (DoH ref: PM0271)], [PM/212 - INQ000120816 (DoH ref: PM0272)], [PM/213 - INQ000120817 (DoH ref: PM0273)], [PM/214 - INQ000120820 (DoH ref: PM0274)], [PM/215 - INQ000120821 (DoH ref: PM0275)], [PM/216 - INQ000120822 (DoH ref: PM0276)], [PM/217 - INQ000346690 (DoH ref: PM0277)].

357. The Review made 19 recommendations for the short-term improvement of the PPE position, which was in preparation for a second wave of Covid-19. 17 associated actions were identified to implement the 19 recommendations. The actions were assessed as either Critical (to be completed within 2-4 weeks) or

Essential (to be completed within 4-8 weeks). A lead official was identified as being responsible for their implementation [PM/218 - INQ000120714 (DoH ref: PM0088)]. Progress on the actions were monitored by the PPE Strategic Supply Cell and whilst the majority of actions were completed in a timely manner, the initial timeframe for completion proved challenging given the nature of some of the actions. Of the 17 actions 15 actions were considered closed by end of August 2020 prior to the commencement of the second wave, and all were considered closed by December 2020.

358. The two actions which took longer to close were in relation to the appropriateness of the reuse of PPE in a period of critical shortage in line with expert scientific advice and the development of systems to enable feedback from end users around the quality of PPE across all HSC and Independent Sector which could be sued to better inform procurement. Both actions required the lead owner, the PHA, to engage with key stakeholders and develop supporting products which impacted on the overall timeline.

Northern Ireland Audit Office (NIAO)

359. The Comptroller and Auditor General for Northern Ireland (C&AG) is head of the NIAO. The C&AG is responsible for:

- authorising the issue of money from the Northern Ireland Consolidated Fund to enable Northern Ireland Departments to meet their necessary expenditure, and for ensuring that there are adequate arrangements for the collection of revenue; and
- the external audit of central government bodies in Northern Ireland, including Northern Ireland departments and their executive agencies and a wide range of other public sector bodies, including executive non-departmental public bodies and health and social care bodies. She undertakes financial audit and value for money audit and the results of her work are reported to the Northern Ireland Assembly.

360. The C&AG works closely with the Northern Ireland Assembly's Public Accounts Committee which takes evidence from senior officials on her reports. The C&AG and the NIAO are wholly independent of Government.

361. In October 2020, the NIAO, contacted the Department advising that it wished to undertake a review of PPE Distribution and Procurement. This was in line with similar reviews undertaken by other audit agencies in the other UK jurisdictions. The NIAO review commenced on 25 March 2021.

362. The 'NIAO Report on '*The COVID-19 pandemic: Supply and procurement of Personal Protective Equipment to local healthcare providers'* (the NIAO Report) was published on 1 March 2022. The NIAO Report identified six areas of learning and these have all been considered by the Department and its relevant Arms' Length Bodies. The Department and its Arms' Length Bodies had all taken action in relation to the learning points in the final report, most of which were already addressed by the time the final report was published.

363. The Department has been asked by the Inquiry to confirm the correctness of two paragraphs in the NIAO Report as follows:

> *3.8 Guidance issued by DoH on 12 March 2020 stated that Independent providers are responsible for sourcing their own PPE equipment. However, in the event that they are unable to source the appropriate items HSC Trusts have been asked to ensure they work closely with independent providers to ensure they have the appropriate equipment available to them if suspected or confirmed cases of COVID-19 arise". Further Departmental guidance on 17 March 2020 stated that whilst ISPs were required to work with suppliers to secure adequate PPE supplies, Trusts would provide support where they were unable to source items. At that time, the core-UK public health guidance (paragraph 3.2) stipulated that standard PPE (aprons and gloves) was sufficient to protect ICS staff from COVID-19, and that enhanced equipment was not required.*
> *3.9 Whilst some ISPs were clearly being issued with PPE through the public sector supply chain in March 2020, IHCP maintains that, at this stage, Trusts were only providing small supplies to care homes when a COVID-19 outbreak had occurred. It considers that these arrangements did not properly address the wider ICS supply shortages, or adequately satisfy public safety interests. It also stated that DOH officials had questioned payment arrangements for any PPE*

which might be supplied to ISPs. In the absence of central supply protocols, IHCP stated that shortages meant some care homes had to make their own PPE, or make appeals for equipment, and some had received donations from the community, charitable and commercial sectors.

364. it should be noted that the full NIAO Report contains 70 pages and, taken in isolation, these two paragraphs do not reflect the wider context identified in the NIAO Report. The Department addresses the NIAO Report further in the Wave 3 Statement.

365. As is the normal NIAO process for preparing their reports for publication, the Department was asked by NIAO to confirm the factual accuracy of the draft report. However, this process does not extend to allowing the Department to challenge or corroborate views and opinions raised by other parties. Therefore, the Department is not in a position to confirm the correctness of this particular section of the report as it relates to the reported views and opinions expressed by the Independent Health and Care Providers to the NIAO at a particular point in time. The Department can confirm that as a matter of fact, the assertions made in paragraph 3.8 of the NIAO Report in relation to guidance issued by the Department are correct. However, in relation to the views recorded as having been told by IHCP to the NIAO, and which are recorded at paragraph 3.9, the Department is not able to confirm whether those representations are factually correct.

SECTION I: THE CARE SYSTEM RESPONSE

366. The Department's response to the pandemic in relation to the care system covered four broad policy areas: care homes (see paragraph 373 to 499 below); domiciliary care (see paragraphs 500 to 514 below); mental health services (see Section J below); and family and children's policy (see Section K below). During the first wave of the pandemic the Department made a number of key decisions in each of these areas to mitigate the impact of Covid-19 by developing and implementing counter measures to address the potential risks to the care system in NI arising from service users contracting the virus in significant numbers and the system's capacity to provide routine services being constrained due to resourcing pressures.

367. At the start of the pandemic the Department asked the Health and Social Care Board to draw up a surge plan for social care [PM/219 - INQ000120731 (DoH ref: PM0146)], which was reviewed, revised and agreed with the Department. This supplemented the Department's published 'Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020' [PM/220 - INQ000103714 (DoH ref: PM0201)] and provided a framework for responding to pressures and maintaining services and was underpinned by plans in each HSC Trust.

368. In the very early weeks of the pandemic, following the activation of Health Gold on 9 March 2020, policy leads from the Department's Social Services Policy Group participated in meetings of the Strategic Cell to monitor the impact of Covid-19 on the social care sector 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 sector. By 6 May 2020 the Department had established, under the Health Gold Strategic Cell [PM/221 - INQ000145672 (DoH ref: PM0167)], a subject specific policy structure for the social care sector, including Domiciliary and Residential Care, and impacts and recovery in relation to psychological impacts and mental health. This structure was chaired by the Department's Chief Social Work Officer and included key senior managers from the Department, Health and Social Care Board, the Chief Executive of the Regulation and Quality Improvement Authority and a Health and Social Care Leadership Centre[12] Associate. The purpose of these discussions was to oversee the Covid response across social care and agree, log and track key actions. The meetings took place through the early weeks and months of the Covid-19 response [PM/222 - INQ000103671 (DoH ref: PM0091)]. During the first wave, and in particular the initial emergency phase, business was conducted within a fast moving and evolving situation, often requiring rapid decision making, responsive to the needs of the sector.

369. In addition, to avoid duplicating structures, Departmental representatives joined key meetings hosted by the Health and Social Care Board and the Public Health Agency. For instance, the Department's Director of Mental Health, Disability and Older People attended weekly meetings chaired by the Health and Social Care

[12] The Health and Social Care Leadership Centre provides a range of management and organisational support to health and social care organisations by developing a range of innovative, high quality and cost effective products and services. The Centre's Associates are individuals who have experience working in the field of management/leadership development or organisational development.

Board which brought together the Directors for Adult Social Care from the Health and Social Care Trusts as well as the Public Health Agency and Regulation and Quality Improvement Authority. This allowed the Department to gather feedback and evidence from frontline organisations to assess impact, share good practice, agree action and inform policy and plan making.

370. There were also frequent and regular *ad hoc* meetings with relevant specialists (such as Public Health Agency consultants or professional staff working in the Department) to test ideas and discuss issues.

371. These structures were developed and refined, with an Adult Social Care Surge Working Group put in place by early August 2020 to further strengthen coordination and collaboration across the Department and wider system [PM/223 - INQ000103715 (DoH ref: PM0202)], [PM/224 - INQ000103716 (DoH ref: PM0203)] and to support the Health and Social Care Board in implementing the regional Care Homes Action Plan [PM/225 - INQ000120732 (DoH ref: PM0148)] they had developed.

372. Structures were also in place to engage with other relevant Executive departments, such as a weekly meeting with officials at the Department for Communities, to share information and, where appropriate, align interventions in supported living facilities and Care Homes. Guidance on homelessness was jointly signed off by the two Departments and the Public Health Agency, for instance.

Care Homes

373. Northern Ireland operates an integrated health and social care system, the commissioning of nursing and residential care home placements is the responsibility of each of the five Health and Social Care Trusts. This differs from other parts of the UK. Each Health and Social Care Trust must contract for Care Home placements at the most competitive rate available, which it considers suitable for meeting the individual's assessed need. Where individuals voluntarily move to a care home setting, the contract is between that individual and the nursing and residential care home of their choice.

374. From the onset of the pandemic the Department recognised that nursing and residential Care Homes would be at the forefront of the battle against Covid-19. The

Department was focused on both limiting infections and their impact in Care Homes as well as ensuring Care Homes could continue to function as an important part of the wider health and social care system.

375. The PHA produced a Health Protection Daily Care Home Outbreak report which identified current and recent outbreaks in individual Care Homes. The report contained no personal identifying information although it did identify the name of the care home, town where it was located and organism identified (diarrhoea and vomiting, Covid-19 or other flu like illness). These reports were produced from April 2020 and are still produced weekly although the content contained within and the format of the report has changed over time. These reports were shared with the Department on a daily basis and were used to provide updates to Executive meetings.

376. Data was also collated through the Regulatory and Quality Improvement Authority as they maintained contact details for all the Care Homes. This data was routinely shared with necessary parties to minimise burdens on homes. The date from the Regulatory and Quality Improvement Authority was used to prepare a weekly dashboard for the Minister which provided a high-level summary of Care Home self-assessed ratings for PPE, Workforce and Cleaning. The dashboard also provided a summary of Trust Surge status based on an analysis of Care Home reported information on the four indicators in the HSCB/PHA Care Home Surge Decision Support Framework (Covid-19 Outbreak; Workforce; PPE & Equipment required for management of Covid-19 and Residents in acute decline).

377. Deaths in care were monitored through a number of mechanisms over the course of the pandemic:

- Deaths occurring in care homes are 'notifiable events' - this means that as part of the formal regulation of care homes by the RQIA, any deaths which occur in the care home setting must be notified by the home to the RQIA. During the pandemic the RQIA produced a weekly data stream, which commenced on 14 May 2020, reporting on deaths occurring in care homes, which they shared with partner organisations, including the Department. The data feed was sent from RQIA to Social Services Policy Group (SSPG) in the Department; colleagues in SSPG used the data feed to provide regular

updates to the Minister and also to inform situational updates and communications briefings/updates. This changed to a fortnightly report from 9 July 2020. These updates were also shared with professional officers in the Department. How RQIA received the data from care homes changed through the course of the pandemic. When RQIA introduced its App for care homes, information on deaths in care homes was in most instances reported through the App, however the principle of care homes advising RQIA of deaths in the care home setting was already established as part of the 'notifiable events' requirements of regulation of the sector this allowed deaths to be monitored.

- Deaths occurring in care homes were also monitored through mechanisms underpinning the publication of official statistics in Northern Ireland. NISRA reported information relating to place of death, as captured through death certification, on a regular weekly basis. In this context deaths occurring in care home settings, in hospitals and/or in hospices were reported on a weekly basis.

- At the outset of the pandemic the PHA established a rapid reporting system to monitor deaths occurring in healthcare settings, which was based on the definition of 'deaths occurring within 28 days of a positive Covid-19 test' and was operated through a Sharepoint system. While this data stream mainly captured deaths occurring in acute settings (namely hospitals) it included some information on deaths occurring in care homes, either because the care home in which the death occurred was an HSC facility and / or the PHA was advised of the death through their programme of support to care homes with incidents or outbreaks of Covid-19.

- Throughout the pandemic the PHA's Health Protection Team delivered a programme of direct support and assistance to care homes for risk assessment and management of incidents and outbreaks of Covid-10. Through this programme the Health Protection Team in PHA were advised at particular points-in-time (e.g. at the time of initial risk assessment) of the numbers of cases and contacts involved in a particular incident / outbreak. The Health Protection Team was also advised if any residents were clinically unwell or had died in the context of the incident. It is important to note this

programme was established to provide operational support to care homes, and not specifically as a system to monitor deaths occurring in these settings.

378. As stated in paragraph 367 above the Department asked the Health and Social Care Board to draw up a surge plan for social care, including care homes. This plan was intended to be dynamic and was updated in response to evolving knowledge and understanding. Separately, scrutiny of this work was undertaken on behalf of the Department with refinements to a phased escalation plan [PM/226 - INQ000103670 (DoH ref: PM0089)], which was then integrated with work being led by Health and Social Care Board, Public Health Agency, Trusts and the Care Home Provider sector. A review of social care sector surge planning was later undertaken on behalf of the Department by an external review team who reported on 1 July 2020 with a series of recommendations for improvement [PM/227 - INQ000103696 (DoH ref: PM0120)].

379. The Department also drew on a wide range of evidence and expert advice to do this, as set out at paragraphs 463 to 470 below.

380. The following paragraphs 383 to 499 set out the Department's key decisions, interventions or mitigations in response to the seriousness and rapid development of the evolving situation, during the "first wave", in the Care Homes sector. This involved the Department supporting the sector through:

- care planning;
- ensuring access to specialist support, guidance, advice and services;
- putting in place dedicated plans, guidance and revised policies;
- quality assurance and performance management;
- providing additional funding and investment;
- ensuring the availability of sufficient stocks of PPE and at the appropriate level;
- delivering a dedicated and customised testing programme for residents and staff;
- providing assistance with workforce pressures including the temporary deployment of staff and the recruitment of additional workforce.
- regulatory flexibility; and
- creating a dedicated Care Homes' team in the Department, increasing engagement with the sector and building new information flows.

Care planning

381. A circular was issued from the Chief Social Work Officer on 2 April 2020 [PM/228 - INQ000103690 (DoH ref: PM0113)], [PM/229 - INQ000360979 (DoH ref: PM0412)] to the Health and Social Care Board confirming that, as from that date and for a period of three months initially, the Department was suspending the requirements under Paragraph 27 of Circular HSC (ECCU) 1/2010 for the need to complete routine Annual Reviews of residents in Nursing and Residential Care Homes.

382. These flexibilities were referenced in the Permanent Secretary's letter of March to Arm's Length Bodies Chief Executives [PM/230 - INQ000103691 (DoH ref: PM0114)] which stated:

> "*We are providing additional flexibilities in the way care home beds are used as well as asking families to accept that patients may be discharged to a nursing home that would not be their first choice or may be discharged home with support from family and friends until a care package is finalised. In addition, we have indicated our expectation that requirements around a range of reviews and assessments and regulatory standards will be interpreted flexibly*."

Support, advice and training

383. On 14 April 2020 the Minister announced [PM/231 - INQ000103692 (DoH ref: PM0115)] that the Regulation and Quality Improvement Authority had set up a Service Support Team to provide help, advice and support to Care Homes and domiciliary care providers. This followed discussions between the Department, Health and Social Care Board, Health and Social Care Trusts and the Regulation and Quality Improvement Authority. The Minister referred to this Support Team in his opening statement to the NI Assembly's Ad Hoc Committee on 14 May 2020 [PM/2326 - INQ000103679 (DoH ref: PM0101)] informing members that the Support Team allowed experienced inspectors with backgrounds in nursing and social work to provide direct advice to Care Homes and domiciliary care providers, with over 1,000 contacts to this team by the 14 May 2020. This approach is reflected in paragraphs 88 to 92 of the 27 April guidance.

384. On 13 May 2020 the Minister announced [PM/233 - INQ000103693 (DoH ref: PM0117)], further intensive support for Care Homes, including strengthening by Health and Social Care Trusts of hospital-to-community outreach teams, building on important work already being done by Care Homes and in partnership with the HSC. It was announced that outreach teams would deliver specialist care and support to older people in Care Homes and their own homes, working in partnership with GPs, district nurses, Allied Health Professionals and social care colleagues. This was designed to facilitate vital initiatives such as virtual ward rounds. A virtual ward round allows clinicians to connect with staff in homes. Using a mobile phone or device, the clinicians could speak face to face with the home about the needs of each individual and could also observe and speak with residents. This assisted in reducing footfall into Care Homes, which was an important infection control priority at that time.

385. The Minister also announced on 27 April 2020 [PM/234 - INQ000103694 (DoH ref: PM0118)] the piloting of a new model for Care Homes: 'Safe at Home'. Building on initiatives already taking place in the sector, the 'Safe at Home' model involved supporting staff who volunteer to work on a rota basis and to 'live-in', either in the care home itself or at a self-contained location nearby. However, following opposition from Trade Unions, it was not possible to establish any pilots for this approach, despite the infection prevention and control advantages it would have brought.

386. In addition, free Infection Prevention and Control training was set up early in the response by both the Northern Ireland Social Care Council and the HSC Clinical Education Centre. This is referenced at paragraphs 28 and 29 of the 17 March 2020 guidance.

387. Support was also put in place with medicines management arrangements, with larger homes being provided with anticipatory care medicines packages as set out in paragraphs 64 to 66 of the April guidance.

Written Guidance

388. Initial guidance for Covid-19 in community care settings was published on 27 February 2020. This was based closely on equivalent guidance published in England, which was assessed by the Public Health Agency for any changes which were required in order to make it relevant to NI before being published on the Public

Health Agency website [PM/235 - INQ000103695 (DoH ref: PM0119)]. This guidance was focused on providing information about Covid-19, how it was spread, and what to do in the case of suspected exposure.

389. Guidance developed by Public Health England and shared with the UK Devolved Authorities was in keeping with extant knowledge and expert professional advice. All such advice was kept under review. For example, the Infection Prevention Control guidance for COVID-19 was developed by the 4 UK nations. This supported not only consistency in practice but importantly a shared understanding of the scientific evidence across the UK. It was essential throughout the development and reviews of the guidance to ensure that it was evidence based and understood by staff, and implementable in all health and care settings. In NI there was neither the need nor capacity to replicate such work. All such guidance was considered in NI by the PHA and the Department's policy and professional officials as to its applicability in NI.

390. As the scale of the response required by Covid-19 became increasingly clear, resources were re-deployed from within the Children and Family Policy Directorate to work with the Director of Mental Health, Disability and Older People on producing revised guidance. This resulted in interim guidance being published on 12 March 2020. The interim status recognised the fact that further guidance would be needed. [PM/236 INQ000103696 (DoH ref: PM0120)] Similar to the February 2020 guidance the focus was on measures to stop the spread of Covid-19, although further detail was also provided on Personal Protective Equipment (including asking Trusts to work closely with providers to ensure they had the appropriate equipment available) and more detail was provided in respect of restrictions to visiting.

391. Dedicated guidance for the management of Covid-19 in residential and nursing Care Homes was first issued by the Department to the sector on 17 March 2020 [PM/237 - INQ000120717 (DoH ref: PM0121)]. A draft of this version was circulated on 14 March to all relevant colleagues within the HSC, including to the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO), the Regulation and Quality Improvement Authority and Public Health Agency colleagues. The guidance set out actions for both Health and Social Care Trusts and for care homes, including clearer asks for Health and Social Care Trusts to work in partnership with nursing and residential Care Homes. Likely challenges with staffing were recognised, there

was more detailed guidance on Personal Protective Equipment, and references were made to infection management and control and admission and discharge.

392. Revised Guidance was re-circulated on 18 April 2020 [PM/238 - INQ000145673 (DoH ref: PM0168)], [PM/239 - INQ000137415 (DoH ref: PM0259)] which included the updated position recommended by Public Health England that anyone discharged from a hospital setting into a care home, including those who tested negative, should isolate for 14 days. This draft Guidance was widely shared around the Department and stakeholders for comments with changes to be supplied by 21 April 2020. A submission went to the Minister on 23 April 2020 [PM/240 - INQ000130356 (DoH ref: PM0176)] for approval to publish the revised guidance. The Minister raised a number of queries on the submission and guidance [PM/241 - INQ000130357 (DoH ref: PM0177)]. The queries were responded to on 24 April 2020 [PM/242 - INQ000130365 (DoH ref: PM0199)] and the Minister approved the guidance on the same date [PM/243 - INQ000130369 (DoH ref: PM0200)]. Notification of the approval was received from Private Office on 27 April 2020 [PM/244 - INQ000130372 (DoH ref: PM0211)]. A letter from the Chief Social Work Officer and the revised guidance issued on 26 April 2020 to Health and Social Care Trusts and the Regulation and Quality Improvement Authority for issue to the sector. The revised guidance was published on the Department's website on 27 April 2020 [PM/245 - INQ000103697 (DoH ref: PM0122)].

393. Guidance that patients discharged from a hospital to a Care Home must be tested for Covid-19 48 hours in advance of discharge, was first set out in Version 3 of the Interim Protocol for Testing for Covid-19 dated 19 April 2020 [PM/101 - INQ000103724 (DoH ref: PM0247)]. Version 3 of the Interim Protocol was communicated to HSC Trusts on 19 April 2020. Updated Departmental guidance on Covid-19 in residential and nursing Care Homes which issued on 27 April 2020 included this updated approach to managing the discharge of patients from hospital to a care home.

394. The requirement that all new admissions to care homes from community settings (including from supported living accommodation) should have their Covid-19 status checked 48 hours before admission to the care home, was first set out in a letter from the Permanent Secretary dated 25 April 2020 (see paragraph 427 below).

395. This much more extensive guidance reflected developing knowledge and understanding as well as feedback from the sector on key issues. The guidance

reflected professional advice from within the Department (from medical advisers and nursing staff) and from the Public Health Agency. While the Department continued to assess and consider guidance provided in England, there were increasingly areas of differentiation to reflect differing requirements and different approaches in Northern Ireland. For example, there was a later point where English PPE guidance recommended the re-use of PPE which was not adopted in Northern Ireland. The Department also didn't differentiate older people's Care Homes from other types of Care Homes.

396. The guidance provided advice on areas such as the use of PPE, testing for staff and residents, staff redeployment and caring for residents in a care home setting.

397. The 27 April 2020 guidance also included the updated approach to managing the discharge of patients from hospital. The guidance directed that all patients who were to be discharged from acute hospital care to a Care Home were to be tested 48 hours prior to discharge. In addition, all patients/residents who were to be transferred into a Care Home from any setting, whether that be from hospital, supported living or directly from their own home, would be tested 48 hours prior to admission to the Care Home. This would help Care Home staff to understand each resident's status and to plan their care effectively. The updated guidance clarified that all patients who were discharged from hospitals into Care Homes – whether they had tested negative or not – should be subject to isolation for 14 days.

398. In addition, all Care Homes were asked to make sure they checked residents and staff twice a day for symptoms of coronavirus. The guidance advised that as symptoms in care home residents can be atypical, increased vigilance was critical. The guidance was reviewed and updated throughout the pandemic with input sought from professional colleagues within the Department and the Public Health Agency and the Regulation and Quality Improvement Authority.

399. In terms of restrictions to visiting, the Chief Nursing Officer issued the first iteration of visiting guidance for healthcare settings in Northern Ireland on 17 March 2020 [PM/237 - INQ000120717 (DoH ref: PM0121)]. She recommended that this guidance should equally apply in nursing and residential Care Homes and other community settings.

400. As updated evidence was becoming available almost on a daily basis, updated guidance was issued on 26 April 2020 [PM/245 - INQ000103697 (DoH ref: PM0122)] which detailed further information for the care home sector regarding visiting restrictions particularly including advice around suitable arrangements for visiting at end of life.

401. Further modifications to the visiting arrangements were made on 11 May 2020 [PM/246 - INQ000120721 (DoH ref: PM0132)]. These modifications relaxed restrictions in certain circumstances, and allowed family, friends or loved ones to safely visit dying patients, and were designed to treat dying patients with dignity and compassion. The modifications applied equally to care home settings and other community settings as well as hospitals.

402. On 30 June 2020 [PM/247 - INQ000103698 (DoH ref: PM0123)] the Minister announced changes to restrictions on visiting across all care settings from Monday 6 July 2020. The revised guidance [PM/173 - INQ000103667 (DoH ref: PM0074)] recognised the right of people to visit their loved ones in hospitals and Care Homes, while balancing the ongoing risk from Covid-19.

Quality assurance and performance management

403. The Department continued to work with relevant bodies throughout this period to ensure that any concerns about the performance of individual Care Homes was addressed.

404. The Department was consulted when consideration was being given to closing a care home or where there were major concerns about a care home or care home provider, in line with agreed regional contingency plans. The Department relied on advice from the Regulation and Quality Improvement Authority and the Health and Social Care Trusts about the impact of any closures and sought reassurance about how they would be managed. Most prominently during this period decisions were taken about Clifton Nursing Home [PM/248 - INQ000137390 (DoH ref: PM0126)].

405. An Early Alert regarding Clifton Nursing Home was submitted to the Department on 19 May 2020 by the Belfast Trust following the Regulation and Quality Improvement Authority inspection on the 15 May 2020. The Regulation and Quality Improvement Authority inspection continued on 21 May 2020. The Regulation

and Quality Improvement Authority, during the inspection, found that that Clifton's management team had not implemented all the actions which previously had been agreed would happen.

406. The Regulation and Quality Improvement Authority indicated they planned to meet with the Responsible Individual/Chief Operating Officer to inform him of their intention to issue a Notice of Proposal to cancel the registration of Clifton. However, at a multi-agency meeting held on 22 May 2020 it was decided that the situation was unsustainable and that arrangements should be made to relocate residents.

407. On 26 May 2020 the Responsible Individual/Chief Operating Officer advised that the home management was to be transferred to another healthcare provider with immediate effect. The Regulation and Quality Improvement Authority did not proceed with the Notice of Proposal to cancel registration.

408. As part of their continuing role, the Regulation and Quality Improvement Authority shared data with the Department which detailed Care Homes by deaths reported to the Regulation and Quality Improvement Authority and the reason for these deaths. As noted, this was part of work to identify risk factors. It also allowed the Department to ask questions about the actions being taken with particular Care Homes. Following provision of this data, the Minister asked a number of questions about the homes with the highest number of deaths [PM/249 - INQ000103699 (DoH ref: PM0125)], [PM/250 - INQ000325177 (DoH ref: PM0413)].

Funding

409. 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.

410. 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 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 put in place 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. The approach was later revised and amended to providing 96% of the pre Covid average payment in April 2021.

411. The Minister announced on 27 April 2020 [PM/234 - INQ000103694 (DoH ref: PM0118)] and [PM/251 - INQ000103686 (DoH ref: PM0108)] 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. This reflected feedback from the sector about the additional costs they were facing as they sought to put in place additional Infection Prevention and Control measures. In order to ensure homes were able to take these measures, additional funding was put in place. 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.

412. The Minister announced further financial support packages of £11.7m on 2 June 2020 [PM/252 - INQ000103701 (DoH ref: PM0127)] and [PM/253 - INQ000103702 (DoH ref: PM0128)] and £27m in October.

413. 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).

414. 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 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).

415. Wherever possible, the Department sought to put in place a claims based system with Care Homes providing evidence of their additional costs (e.g., for enhanced cleaning) and claiming these costs. In other categories it was accepted that it might be difficult to evidence the additional burden precisely, therefore payments were put in place based on set criteria. Health and Social Care Trusts were asked to oversee this claims process. Business Services Organisation provided Health and Social Care Trusts advice on the most effective approach to this process, to minimise fraud.

416. Following on from the Minister's announcements of additional funding packages of initially £6.5m, and then a further £11.7m, to care home providers during the pandemic, the Department wrote to the Director of Social Care and Children, Health and Social Care Board Directors of Older People's Services, and Health and Social Care Trusts on 30 June 2020 to clarify a number of eligibility queries and establish a mechanism to monitor and report on spend against these allocations.[PM/254 - INQ000103703 (DoH ref: PM0129)]

PPE

417. A Care Home sector representative (a Director of the Independent Health Care Providers) was included on the Business Services Organisation's structures overseeing work on the provision of PPE in the very early stages of the pandemic.

418. However, following engagement with the Business Services Organisation and the sector, interim guidance on 12 March 2020 [PM/227 - INQ000103696 (DoH ref: PM0120)] provided further detail in relation to PPE. The guidance was not submitted to the Executive as it was not considered to be cross cutting and had no direct impact on other Executive Departments at that time. The guidance stated that in the event independent providers were unable to source the appropriate items Health and Social Care Trusts should ensure they work closely with independent providers to ensure they have appropriate equipment available. This requirement was expanded on and detailed in later versions of the guidance, addressing feedback from the sector. The procurement and supply of PPE for Care Homes was therefore partially centralised through the Business Services Organisation. A Departmental news release [PM/231 - INQ000103692 (DoH ref: PM0115)] issued on 14 April 2020 announced that:

> "*in the past week 1.7 million items of PPE have been distributed by Trusts to the Independent sector which includes Care Homes and domiciliary care settings. This includes 637,000 gloves, 413,000 plastic aprons and 400,000 liquid repellent surgical masks". In his statement of 27 April 2020* [PM/234 - INQ000103694 (DoH ref: PM0118)], *the Minister stated: "ensuring that Care Homes have sufficient supplies of PPE is an absolute priority, and Trusts will work with Care Homes in their areas to ensure that each home has a buffer of PPE stock*".

419. In addition, Construction and Procurement Delivery in the Department of Finance were circulating details of providers of PPE to the wider public sector. The Department engaged with Regulation and Quality Improvement Authority at the time and then asked the Department of Finance to include Regulation and Quality Improvement Authority on the distribution list for providers of PPE so that details of PPE providers could be circulated to independent providers such as Care Homes, helping them to access PPE.

420. It is important to note the context of a challenging PPE position across all providers including HSC Trusts. When informed that HSC Trusts were only making limited supplies to care homes and that there was inconsistency across the region, the Department asked all homes to put in place a 'buffer' stock in care homes. The Department planned to convene a meeting with HSC Trusts to discuss how an adequate buffer could be put in place. However the issue was resolved before the

meeting took place and therefore the meeting did not happen. The Department also contacted a number of care homes directly following receipt of a list (from the Independent Health Care Providers) of care homes with issues but found that the issues with supply flagged by the Independent Health Care Providers had already been resolved. At least one HSC Trust noted informally that some care homes seemed to be using very high quantities of PPE. This may have reflected practice that went beyond official guidance at the time about when and what type of PPE was necessary. This may in turn have contributed to tensions between expressed care home requirements and what HSC Trusts were willing or able to provide.

421. It was a constantly evolving situation and the Department continued to ensure that the provision of such Guidance remained contemporaneous.

422. Faced with hugely increased demand and supply constraints, BSO PaLS initially struggled to build sustainable PPE stocks. Its existing contracts proved incapable of providing reliable supplies, and it held less than one week's supply of most items throughout most of March 2020.

423. There was evidence of PPE shortages across the HSC sector and ICS nursing and residential homes well into April 2020. However, as supply pressures eased, the total number of core PPE items delivered to healthcare providers increased, as per [PM/231 - INQ000103692 (DoH ref: PM0115)] above.

424. Subsequent Care Homes Guidance issued on 17 March 2020 [PM/255 - INQ000353598 (DoH ref: PM0377)]:

(a) requested that the Trusts work with nursing and residential homes on the provision of appropriate PPE.

(b) Where homes are unable to source appropriate PPE provision, Trusts were to take into account into account these needs when seeking supplies from the Business Services Organisation.

(c) Trusts had to work with homes to understand requirements and prioritise stock across organisations, where there are any short term limitations on stock. Trusts were to ensure all nursing and residential homes had a named point of contact with whom to discuss PPE provision.

(d) Homes were not to be charged for the provision of PPE from Trust stocks.

425. The guidance at the time stated that if neither the care worker nor the individual receiving care and support is symptomatic, then no personal protective equipment is required above and beyond normal good hygiene practices.

Testing Programme

426. Care Homes are distinct from other care settings; they are enclosed environments and have a specific and particular risk profile; and residents are often considered to be at greater risk to Covid-19 due to their individual clinical vulnerabilities. Testing for Covid-19 was therefore part of a package of comprehensive measures for Care Homes in Northern Ireland, recommended and advised by the Department from early on in the pandemic. Care Home residents were identified as a priority group for testing, as evidenced in the early prioritisation criteria which were agreed for the region on 17 March 2020 and included in the first Interim Protocol for Testing, operational from 20 March 2020 [PM/100 - INQ000120705 (DoH ref: PM0056)].

427. A letter dated 25 April 2020 from the Permanent Secretary to Chief Executives (Health and Social Care Trusts, Public Health Agency, Health and Social Care Board, NI Ambulance Service, and the Regulation and Quality Improvement Authority) about key changes to testing for Covid-19, also reiterated the requirement for patients discharged from hospital to a care home to be tested 48 hours in advance of discharge. In addition, this correspondence advised that all new admissions to care homes from community settings, including from supported living accommodation, should have their Covid-19 status checked 48 hours before admission to the Care Home [PM/256 - INQ000145670 (DoH ref: PM0136)].

428. Northern Ireland moved before other parts of the UK to increase Covid-19 testing across its Care Homes; testing progressed in a phased way during the first wave of the pandemic and beyond, from initial Covid-19 testing of Care Home residents and staff displaying symptoms, to Covid-19 testing made available to all residents and staff.

429. The initial approach to Covid-19 testing in individual Care Homes was informed/guided by the approach previously taken in the context of influenza outbreaks. The testing approach was actively and continually reviewed, with

decisions relating to expanding and implementing Covid-19 testing informed by SAGE and its subgroups, the emerging scientific evidence, and advice from the Department's Expert Advisory Group on Testing.

430. Some of the key policy considerations for the Department to support and enable this sustained programme of testing included for example, the acceptability of the programme to residents and staff, testing capacity, logistics and oversight, and finance.

431. PHA managed the detail of establishing and maintaining the testing programme in care homes, and of the delivery, logistics and operations. The collaborative and robust multi-agency working partnership including between the Department, PHA, HSC Trusts, the NI Ambulance Service, the care homes themselves and the Pillar 1 and Pillar 2 testing programmes enabled the successful delivery of testing (see paragraph 218 above).

432. From 12 April 2020, Covid-19 testing arrangements were put in place for all symptomatic residents and staff in care homes settings if/when a care home had a possible outbreak or cluster of infections. Prior to this policy change, a maximum of 5 residents were tested in each care home reporting a possible outbreak or cluster.

433. On 27 April 2020 [PM/234 - INQ000103694 (DoH ref: PM0118)] the Minister announced that testing would be carried out on all staff and all residents in Care Homes when a home was identified to the Health Protection team in the Public Health Agency as having a potential outbreak or cluster of infections. The previous approach had been to only test staff and residents when they had been displaying symptoms. In a further statement on 13 May 2020 [PM/233 - INQ000103693 (DoH ref: PM0117)] the Minister announced a significant expansion of testing for Care Home residents and staff. This expanded approach had been informed by advice being prepared for Government and the NHS by the Scientific Advisory Group for Emergencies and the Department's Strategic Intelligence Group (SIG).

434. Ahead of this expansion, the Northern Ireland Ambulance Service had been providing a mobile testing service for Care Homes. This service was integrated into the Health and Social Care Trusts and Public Health Agency/Health and Social Care Board teams who were working with and providing support to Care Homes. In

addition, up to 40 nurses from the HSC were deployed to support testing in Care Homes.

435. On 18 May 2020 [PM/257- INQ000103704 (DoH ref: PM0143)], the Minister announced that Covid-19 testing would be made available to all Care Home residents and staff across Northern Ireland; this included Care Homes which did not and had not previously experienced a COVID-19 outbreak. The Minister said it was intended to complete the roll-out of testing to all residents in June 2020. The Minister wrote to all care home providers on 19 May 2020 about these extended Covid-19 testing arrangements. The initial phase of this extensive testing programme completed in all care homes across NI at the 30 June 2020.

436. This extended programme of Covid-19 testing in Care Homes was delivered through two distinct pathways: testing in Care Homes with suspected or confirmed Covid-19 outbreaks, and testing in 'green' Care Homes, that is those homes which did not had a Covid-19 outbreak. Health and Social Care Trusts were responsible for administering the testing programme for Care Homes which had or were in outbreak. The National Testing Programme supported the independent sector and the Health and Social Care Trusts to test all residents and staff in the 'green' Care Homes.

437. To provide effective direction and guidance to ensure the successful completion of this phase of Covid-19 testing across Care Homes, and to effectively determine future care home testing requirements, the Chief Medical Officer (CMO) established a Care Home Task and Finish (T&F) Group. This group, chaired by the Deputy CMO, included key representation from the Department and its Expert Advisory Group on Testing, the Public Health Agency, and the Regulation and Quality Improvement Authority. This group met for the first time on 8 May 2020, with subsequent meetings scheduled on a regular basis.

438. By 30 June 2020, staff and residents in all Care Homes across Northern Ireland had been offered Covid-19 testing. In view of the logistical challenges associated with undertaking such an extensive programme of testing, across a significant number of facilities in a relatively short period of time, this was a positive outcome. The successful completion of this phase of the care home testing programme was made possible through a collaborative and robust multi agency working partnership between the Department, the Public Health Agency, the Health

and Social Care Trusts, the NI Ambulance Service and importantly, the Care Homes themselves.

439. On 28 July 2020, the Minister announced the next phase of testing in Care Homes [PM/258 - INQ000103705 (DoH ref: PM0144)]. A rolling programme of regular Polymerase Chain Reaction (PCR) testing, started on 3 August 2020, for all residents and staff in 'green' Care Homes which did not have a confirmed outbreak of the virus, with the aim of helping to keep these homes free of Covid-19. At that point, it was recommended that asymptomatic staff should be tested on a fortnightly basis and asymptomatic residents tested monthly. The Minister also referred to the start of the rolling programme in his statement to the NI Assembly on 28 July 2020 [PM/259 - INQ000103706 (DoH ref: PM0145)]. In addition to the rolling programme of asymptomatic care home testing, an enhanced testing protocol was in place for Care Homes with a suspected or confirmed Covid-19 outbreak.

440. A subsequent programme of regular Covid-19 PCR testing for care homes which did not have a Covid-19 outbreak commenced on 3 August 2020 (at that point all asymptomatic care home staff were tested on a fortnightly basis, with all care home residents tested on a monthly basis).

Workforce Recruitment

441. Early on in the pandemic, Care Home providers identified staffing pressures as an issue. While data from the social care regulator, Northern Ireland Social Care Council, identified that the number of registered social care workers had increased, increased demands across the sector and requirements for self-isolation meant significant challenges remained. The Department therefore took a number of steps to help address this challenge, including asking Health and Social Care Trusts to step in and provide staff to Care Homes were there were no other options.

442. To help address some of the challenges Health and Social Care Board's Director of Social Services wrote to all Health and Social Care Trusts on 15 April 2020 [PM/260 - INQ000120733 (DoH ref: PM0150)], activating a 4 Stage Mutual Aid and Resilience Planning process that ranges from activation of a Home's contingency plans to direct recruitment of volunteers.

443. The Department continued to monitor the position by asking Health and Social Care Trusts for information on the number of shifts they were being asked to help fill by Care Homes [PM/261 - INQ000103708 (DoH ref: PM0151)]. The Department established a regular data feed from Care Homes through the submission of the Regulation and Quality Improvement Authority's data returns, which asked Health and Social Care Trusts to RAG (i.e. Red / Amber / Green risk) rate their staffing position. The Department was aware that the position in a single home could change very quickly if there was a significant outbreak.

444. Summarising the approach taken by the Department, on 27 April 2020 the Minister announced [PM/234 - INQ000103694 (DoH ref: PM0118)] that Health and Social Care Trusts would continue to work in partnership with care home providers to help deal with staff shortages. The Minister announced that where people had responded to the Department's Workforce Appeal, those with the right skills would be prioritised for deployment with independent care home providers. He also confirmed that Trust staff had already been redeployed to Care Homes and would continue to be. The Minister's statement noted that the provision of nursing care was essential, and in particular that those registered nurses who had transferable skills, expert knowledge and experience of caring for older people in a range of other settings should feel encouraged to come forward and play their part in keeping vulnerable people out of hospital and in their own home.

445. Health and Social Care Trusts also stepped in to provide thousands of hours of free staffing time to homes that needed it. By 7 May 2020 one Health and Social Care Trust alone had provided 1,700 hours of staff time. This support included:

- Additional nursing staff to assess and treat residents who had increased health care needs;
- Ward rounds with primary care which involved medical practitioners assessing and recommending treatment and management plans for individual nurses;
- Infection prevention control nurses to support management within the units;
- Social workers supporting family liaison work to maintain good communication between the resident and family members;
- Hospital diversion staff who assessed and treated residents with high complex needs;

- Palliative care staff who supported the treatment and management of resident with end of life care;
- Dementia homes support staff who provided guidance and direct care to residents with complex needs associated with their dementia;
- Provision of deep cleaning services

446. As a core element of the overall strategy to mitigate infection in care homes Health and Social Care Trusts were also asked to ensure staff did not move between homes, given the risks of transferring infection.

447. In addition, the Department prioritised any professional staff returning to the HSC for deployment into the Care Home sector where their skills and experience matched requirements. The Department also re-prioritised professional staff from arms lengths bodies to provide direct support to or in Care Homes. This was in addition to support already provided by Health and Social Care Trust staff to Care Homes in their areas on these issues.

448. In addition to the above measures, the Department worked with regulators such as the Northern Ireland Social Care Council and with the universities to help social work and nursing students qualify early, allowing them to enter the workforce early and boost staffing numbers.

449. Both the Chief Nursing Officer and Chief Social Work Officer made workforce appeals to help increase the numbers of available staff, while the Northern Ireland Social Care Council emailed all staff on the social care register and also suspended collection of the annual £30 registration fee to ensure there were no barriers to engagement. Processes for recruiting staff were also streamlined by way of changes to the employment vetting policy. The changes permitted employers to recruit staff quickly to health and social care posts through more limited pre-employment checks in anticipation of staffing pressures [PM/262 - INQ000120734 (DoH ref: PM0153)], [PM/263 - INQ000130348 (DoH ref: PM0154)], [PM/264 - INQ000130346 (DoH ref: PM0116)], [PM/265 - INQ000120735 (DoH ref: PM0155)], [PM/266 – INQ000130349 (DoH ref: PM0157)], [PM/267- INQ000130350 (DoH ref: PM0158)], [PM/268 - INQ000130351 (DoH ref: PM0159)], [PM/269 - INQ000130347 (DoH ref: PM0135)], [PM/270 - INQ000120736 (DoH ref: PM0160)], [PM/271 - INQ000120737 (DoH ref: PM0161)], [PM/272 - INQ000120740 (DoH ref: PM0162)], [PM/273 - INQ000120745 (DoH ref: PM0164)]. In support of the policy, the Department introduced the

Establishment and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2020 in April 2020. In addition, AccessNI (an arm's length body run by the Department of Justice) put in place an emergency Barred List Check mechanism, which facilitated the safe recruitment of staff more quickly. The temporary policy was stood down when pressures eased in September 2020 and AccessNI closed the Barred List Check scheme around the same time. The Department revoked the Establishment and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2020 in July 2021.

450. The Department also recognised that staff retention and wellbeing was an important issue, ensuring independent sector social care staff had access to Trust wellbeing helplines and other support services. Further, the Department was supportive of a proposal from the PHA to fund the creation of rainbow rooms [PM/274 - INQ000103710 (DoH ref: PM0165)]. A Rainbow Room is a space for care home staff to go for solace when the pressures of dealing with coronavirus became too much. The proposal was to support the delivery of a Rainbow Room resource box to every care home in Northern Ireland.

Regulatory flexibility

451. In a letter from the Chief Medical Officer, on 20 March 2020 [PM/275 - INQ000103688 (DoH ref: PM0111)], the Department gave direction to the Regulation and Quality Improvement Authority to reduce the frequency of its statutory inspection activity as set out in the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005 and cease its non-statutory inspection activity and review programme with immediate effect until otherwise directed.

452. The Regulation and Quality Improvement Authority maintained an inspectorate function and continued to take enforcement action where necessary over the course of the pandemic.

453. The level of the Regulation and Quality Improvement Authority's inspectorate function varied in line with the HSC response to the pandemic. On 20 March 2020, the Department gave direction to the Regulation and Quality Improvement Authority [PM/275 - INQ000103688 (DoH ref: PM0111)] to reduce the frequency of its statutory inspection activity and cease its non-statutory inspection activity and review

programme with immediate effect until otherwise directed. This direction was to enable the Regulation and Quality Improvement Authority to prioritise inspections on an evidence, intelligence led and risk-assessed basis to focus their activity where it was most needed in a flexible and proportionate manner.

454. In June 2020 the acting non-executive Chair and six non-executive members of the Regulation and Quality Improvement Authority Board resigned with immediate effect. Christine Collins was appointed as interim Chair to the Regulation and Quality Improvement Authority on 18 June 2020. Two Departmental Officials were temporarily appointed as non-executive members of the Regulation and Quality Improvement Authority Board until the 30 October 2020 when six interim non-executive members were appointed to the Board.

455. On 23 June 2020 the Department announced it had commissioned an independent Review of the circumstances that gave rise to the resignation of the RQIA Board members. The independent Review was published by the Department on 19 July 2021 alongside an action plan detailing the Department's response.

456. During this period as a key support mechanism, the Regulation and Quality Improvement Authority was asked and agreed to establish a Service Support Team to act as the point of contact for providers of adult residential and nursing homes, domiciliary care and supported living services who had questions and issues arising from the pandemic [PM/276 - INQ000137410 (DoH ref: PM0236)]. The main objective of this exercise was to ensure that providers had a single point of contact to raise issues and receive the most up to date advice, guidance and support from the Regulation and Quality Improvement Authority's expert teams of inspectors who; for those supporting this function; were all registered nurses, social workers or Allied Health Professionals. The Regulation and Quality Improvement Authority had key points of contact identified in each Trust in order to ensure the information being passed on was the most current and also in order to refer specific queries if they were unable to resolve the matter. In addition, the Regulation and Quality Improvement Authority were afforded broad flexibility to work with providers to find bespoke solutions to specific issues beyond the remit of generic standards or regulations, to provide safe, pragmatic remedies on a case by case basis. While care home, domiciliary care and supported living providers will be able to reflect their experience, the Department believes that this support was well received.

457. In this vein the Northern Ireland Social Care Council modified their approach to fitness to practice issues to lessen the burdens on the system while keeping a focus on those cases most likely to present a risk to the public.

458. Following a review of the Department's direction, of 20 March 2020, given a reduction in community transmission and in light of the recovery process and rebuilding of HSC services, the Department rescinded the direction to the Regulation and Quality Improvement Authority [PM/277 - INQ000346700 (DoH ref: PM0379)] on 22 June 2020.

459. The detail of how the Regulation and Quality Improvement Authority discharged its inspectorate function during the period of greater regulatory flexibility is an operational matter. The Regulation and Quality Improvement Authority would be best placed to provide an accurate response on the detail of how this function was discharged.

460. Following a request from the Health and Social Care Board the Department agreed a number of more flexible measures to recognise the potential loss of capacity in the sector and ensure the HSC system could continue to operate effectively. These flexibilities included arrangements in relation to dementia beds. In this regard, following a request from Health and Social Care Trusts and the Health and Social Care Board, the Department wrote to HSCB on the 18 March 2020 [PM/278 - INQ000103689 (DoH ref: PM0112)] confirming they were content for commissioning organisations to place dementia/delirium patients into beds currently registered for other purposes, should this become necessary, given the likely pressure that acute services would be under as the Covid-19 peak approached. There were a number of safeguards put in place along with this measure. For example, individuals were only to be placed for the duration of the Covid-19 surge; efforts to find a registered dementia bed were to continue once a placement was made and be ongoing until a bed was found; there was to be ongoing and active case management; the care in the setting the individual was placed in was appropriate to need; and the care provider was involved in the decision-making and content with the approach to managing risk.

Expert advice

461. Alongside these meetings and structures expert advice was sought from relevant organisations and cells to input to specific pieces of work. For instance, the testing cell provided advice on issues related to testing in Care Homes and on discharge which was reflected in guidance issued to Care Homes; advice on infection prevention and control issues was received from the Director of Nursing and specialist infection, prevention and control nurses in the Public Health Agency Generally, any debate on the appropriate position to take would have been resolved through these mechanisms and then reflected in guidance and communications to the Care Home sector. The approach taken was to assess the risk, examine options to mitigate the risk, agree actions to be taken and, where appropriate, to obtain advice from the Department's lead professional officers, such as the Chief Medical Officer or Deputy Chief Medical Officer.

462. While the Department closely scrutinised and often followed guidance set in England there would occasionally be differences in approach, for instance on whether it was safe to re-use PPE (as referenced in the PPE section of the April guidance to Care Homes). Where appropriate, guidance would often directly reference UK Government or Public Health England guidance where local equivalents were not available. Where guidance or material from the Public Health Agency was available, this would normally be referenced or linked to instead.

463. In addition to specific questions and queries, there was a broad request for evidence of best practice and effective interventions in a Care Home context which was sought from the Public Health Agency [PM/279 - INQ000103675 (DoH ref: PM0095)] and from the Chief Scientific Officer [PM/280 - INQ000103676 (DoH ref: PM0096)].

464. Modelling of Care Home outbreaks in other parts of the UK was shared by those administrations with the Public Health Agency and the Department [PM/281 - INQ000103677 (DoH ref: PM0098)]. In a modelling paper, dated 18 April 2020, the Public Health Agency provided Northern Ireland specific modelling which looked at the trajectory of Care Homes outbreaks in NI and the modelling suggested the need for further intervention given the rising number of Care Home outbreaks [PM/282 - INQ000137411 (DoH ref: PM0237)]. The Department also sought to compare death

rates in Care Homes across the UK in order to identify if there were significant differences which could be explained by policies or approaches. However, the close relationship between community infection levels and outbreaks in Care Homes made this challenging, along with other issues such as the different profile of the sector in different countries [PM/283 - INQ000103678 (DoH ref: PM0100)]. Despite these challenges, it was still clear that the proportion of homes with outbreaks in NI was significantly lower than in other parts of the UK at a point in time. The Minister referenced this in his opening statement to the Ad Hoc Committee of the NI Assembly on 14 May 2020 [PM/232 - INQ000103679 (DoH ref: PM0101)], when he reminded members that for every home with either a confirmed or suspected outbreak, there were three that did not, and whilst noting the difficulty of drawing comparisons, suggested this compared favourably to other parts of these islands. The Department did not routinely compare the proportion of homes with outbreaks in NI with those in other parts of the UK. However, The International Long Term Care Policy Network produced a paper in August 2020 [PM/284 - INQ000325171 (DoH ref: PM0380)] on Covid-19 mortality and long term care: a UK comparison. One of the findings in the report was that "In Northern Ireland, where weekly deaths per 100,000 remained lower than any other nation throughout the pandemic period".

465. The Office for National Statistics (ONS) article released on 15 March 2023, entitled "Deaths in care homes, UK: 2015 to 2021" [PM/285 - INQ000325172 (DoH ref: PM0381)] provided a summary of the definitional differences of care home deaths across the four nations, and the feasibility and limitations of producing a UK-wide statistic for deaths in care homes. Analysis of the trends in total deaths, deaths involving coronavirus (COVID-19) and leading causes of death in care homes in England, Wales, Scotland, and Northern Ireland are presented.

466. The PHA's modelling paper, dated 18 April 2020, was produced in the early stages of the development of the various support mechanisms provided to care homes. This led to a number of key decisions, interventions or mitigations, set out in paragraphs 392 to 462 above, in response to the seriousness and rapid development of the evolving situation. This included actions in relation to care planning; ensuring access to specialist support, guidance, advice and services; putting in place dedicated plans, guidance and revised policies; quality assurance and performance management; providing additional funding and investment; ensuring the availability of sufficient stocks of PPE and at the appropriate level;; providing assistance with workforce pressures including the temporary deployment of staff and the recruitment

of additional workforce, regulatory flexibility; and creating a dedicated Care Homes' team in the Department, increasing engagement with the sector and building new information flows.

467. To ensure the Department was learning from international best practice the Chief Social Worker Officer engaged with the International Long Term Care Policy Network, which provided the Department with access to country reports on Covid-19 and long-term care. These reports enabled the Department to undertake gap analysis, comparing international practice to the Department's interventions in NI [PM/286 - INQ000103680 (DoH ref: PM0102)] and this confirmed that there were no significant gaps in our actions.

468. The Department also worked closely with the Regulation and Quality Improvement Authority who undertook work to assess the ability of different Care Homes to implement isolation policies and the effect of this (given, for instance, a small number of homes still used some double occupancy rooms). This was referenced at paragraph 30(c) of the April 2020 guidance. In correspondence from the Chief Social Work Officer in April 2020, the Regulation and Quality Improvement Authority was asked to look at the correlation between different risk factors and which Care Homes had outbreaks [PM/287 - INQ000103681 (DoH ref: PM0103)], [PM/288 - INQ000103682 (DoH ref: PM0104)] and [PM/289 - INQ000103683 (DoH ref: PM0105)] which identified a number of important correlations which informed ongoing regulatory activity and monitoring.

469. Account was taken of evidence from studies such as Vivaldi as they emerged [PM/290 - INQ000103684 (DoH ref: PM0106)], [PM/291 - INQ000346701 (DoH ref: PM0382)]. The Vivaldi 1: Covid-19 Care Homes study report published on 3 July 2020 examined Covid-19 infections in 9,081 Care Homes in England (all with responsibility for providing dementia care or care for older residents (aged 65 years and over), and survey results of managers of those Care Homes; 5,126 Care Homes responded to the survey. It produced a number of conclusions in relation to risk factors for infection in residents and staff.

470. The key findings from the Vivaldi study were:

- Regular use of bank staff is an important risk factor for infection in residents and staff.
- Infections in staff are a risk factor for infection in residents and infections in residents are a risk factor for infection in staff. However, the magnitude of this effect suggested staff are more likely to transmit infections to residents than vice versa.
- Emerging data suggest that the number of new admissions and return of residents to the care home from hospital may be important risk factors for infection in residents and staff. This has only been tested in unadjusted analysis due to a high proportion of missing data across these variables.
- Region is an important risk factor for infection in staff and residents, but its effect is different in staff and residents. This may be due to differences in the timing of testing between staff and residents.

471. The Vivaldi findings were considered in the Department's approach to managing the outbreak of Covid-19 in care homes. For example, the Department was involved in the development of guidance issued by the HSCB and PHA in January 2021 regarding key principles for bank and agency staff. The Covid-19 guidance for nursing and residential care homes also stated that "As far as possible homes should seek to limit turnover in staff they use and seek to limit the number of staff moving between different homes". [PM/2892 - INQ000325173 (DoH ref: PM0383)]

472. A further example relates to the work undertaken by the Department to introduce a regular planned programme of Covid-19 testing in care homes across Northern Ireland. Specifically, the Vivaldi study's suggestion that care home staff were more likely to transmit infections to residents than vice versa, contributed to the evidence to appropriately inform the proposed testing approach for care homes which did not have a Covid-19 outbreak. The Department's initial testing proposal had suggested monthly Covid-19 testing of residents and staff in care homes without a Covid-19 outbreak [PM/293 - INQ000346702 (DoH ref: PM0384)]. Taking the Vivaldi findings into consideration, the Department subsequently adopted a more frequent testing approach, with care home staff advised to test for Covid-19 every 14 days rather than monthly. [PM/294 - INQ000346703 (DoH ref: PM0385)]. As explained at paragraph 439, this rolling programme of regular PCR testing started on 3 August 2020.

473. The Department maintained close contacts with a range of governmental partners and key stakeholders to share information, experience, and best practice. Paragraphs 474 to 479 below provide details of the Department's interaction with the NI Executive and other NI departments; the UK government and the devolved administrations in Scotland and Wales; the social care authorities in the Republic of Ireland; the Department's arm's length bodies, principally the Health and Social Care Board, Public Health Agency, Regulation and Quality Improvement Authority and the Health and Social Care Trusts. The Department also deepened its longstanding working relationships with the organisations representing the independent Care Homes sector, trade unions and the Commissioner for Older People, see paragraphs 480 to 487 below.

Engagement with the Executive

474. On 17 April 2020 the Minister provided an overview paper to the Executive on Care Homes, updating them on reporting of deaths, PPE, testing and measures under development to support Care Homes [PM/295 - INQ000103672 (DoH ref: PM0092)] and [PM/296 - INQ000103673 (DoH ref: PM0093)]. Subsequently, action 112 of the Executive's Covid-19 Action Plan (May 2020) requested quantitative information on the actions taken within Care Homes to reduce infection and their effect. The Minister submitted a paper to the Executive in July 2020 [PM/297 - INQ000103717 (DoH ref: PM0208)] which set out a timeline of the range of actions taken to respond to the Covid-19 pandemic in Care Homes and provided information on the course of the infection in Care Homes over the same period. A further Executive Paper was produced by the Department in November 2020. This paper provided the Executive with an update on measures to support and protect Care Homes as Covid-19 continued to spread in the community and as infection levels in Care Homes continued to rise [PM/298 - INQ000103674 (DoH ref: PM0094)].

Liaison with Republic of Ireland and GB Counterparts

475. The Department's senior officials remained in direct contact with their counterparts in the other UK administrations throughout the first wave. The Department's Director of Mental Health, Disability and Older People attended the meetings of the Adult Social Care and Covid-19 devolved administrations information sharing group from early April. This group, which met every two weeks initially,

shared information about the Adult Social Care Covid-19 response in each nation focusing on their respective key plans, policies, pressures, and risks. The group was sometimes used to give early warning of significant new guidance or plans being launched by England. There were follow-up meetings between nations where there were particular interests: for instance, Wales sought a more detailed understanding of our financial support for Care Homes; or more detailed discussions between nations on visiting policies. The group also promoted a joined-up approach concerning policy advice provided to Ministers and other cross-nation briefing and initiatives. This was to ensure a consistent and comprehensive assessment of the UK's Adult Social Care Covid-19 response.

476. Information obtained by the Department's officials during these meetings, along with other sources of information, contributed to advice given to the Minister in relation to a range of policy areas to ensure a consistent approach with the rest of the UK when possible and where this was appropriate to do so.

477. The Department's Chief Social Worker had several meetings with the Director General for Social Care in the Department of Health and Social Care (DHSC) at which the pandemic response was discussed. The Chief Social Worker also attended regular meetings of the Chief Social Workers across the four UK Nations. These meetings involved sharing intelligence on the impact of the pandemic and benchmarking mitigation measures.

478. These interfaces with the other UK jurisdictions allowed the Department to check and benchmark our approaches and develop new interventions where appropriate. Despite the structural differences between NI and the other parts of the UK, in relation to policy development and service delivery, there are several examples of learning and sharing approaches that we would highlight.

- In drafting guidance, such as that for Care Homes, the Department drew on published guidance in England, for instance. We also drew on advance sight of the adult social care winter plan to consider our own approaches to, for instance, discharge from hospital.

- In developing a £500 recognition payment for social care staff we looked closely at the approach taken in Scotland. We considered how to use the expertise of Independent Living Fund Scotland, given their role in the

Scottish system and their existing role making Independent Living Fund payments to NI recipients and used them deliver payments to Independent Living Fund recipients for onward transmission to their carers.

- Obtaining early sight of proposed English guidance on visiting social care institutions (e.g., Care Homes) over the Christmas period alerted the Department to the issue and helped inform the development of our own approach and guidance.

- The Department also obtained information on the scale of, and approach to, financial support for social care providers across the UK and used this to benchmark our proposals and inform the advice to the Ministers. This included assessing the approaches taken in other jurisdictions to funding enhanced sick pay for care workers, for instance.

479. There was also contact between senior officials and the Health Service Executive in the Republic of Ireland to discuss issues related to Care Homes, social care and mental health. These meetings involved sharing intelligence on impact, benchmarking mitigation measures and confirming our understanding of initiatives in that jurisdiction [PM/299 - INQ000103685 (DoH ref: PM0107)].

Sector Engagement and Communication

480. The Department engaged extensively with the key stakeholders and representatives of Care Home residents, to seek feedback on service delivery and the challenges faced by the sector. This engagement also tested or gave early warning of new approaches, policies, initiatives, and guidance that the Department was proposing or implementing to respond to, in relation to the impact of the virus on adult social care services.

481. These stakeholders included: the Independent Health and Care Providers, the UK Homecare Association, and the Association for Real Change. There was direct contact with several individual providers, most frequently with Four Seasons and Healthcare Ireland. There was also contact with voluntary organisations, principally AgeNI, CarersNI and Care Home Advice and Support NI.

482. There was also regular engagement with the Commissioner for Older People in NI, with Trade Unions such as Unison and the Royal College of Nursing; engagement with a group formed of the relatives of individuals in Care Homes. This group was established by the Public Health Agency and the Patient Client Council. The Department's officials also attended meetings of the NI Assembly Health Committee and the Assembly All Party Group on Carers.

483. The Minister sought to make clear the priority placed on Care Homes, for instance the Minister's statement to the Ad Hoc Committee on 14 May 2020 [PM/232 - INQ000103679 (DoH ref: PM0101)] stressed the priority put on Care Homes and the support being provided to them. The Minister also met with representatives from the Care Home Sector on 1 June 2020 and again on 30 July 2020 and a number of both committee appearances and press releases were used to stress the importance put on social care and on Care Homes. This, in part, reflected feedback from the sector about the importance of public messages for both morale and recruitment and retention. As part of this response, we ensured that social care was a focus at one of the Executive public briefings on Covid-19, led by Department's Chief Social Work Officer on 2 June 2020.

484. While much of the communication with the sector was through phone calls with sector representatives or in the course of small roundtable meetings, such as that on 16 March 2020 to discuss guidance or on 26 July 2020 to consider Financial Year Q2 and Q3 financial support. There were also larger meetings involving a wider range of officials and stakeholders.

485. For instance, the Department's senior officials (The Chief Social Work Officer, Chief Nursing Officer and members of their teams) met with key representatives of the independent homecare sector on 26 March 2020 to discuss the impact of Covid-19 on the sector. Following these discussions, the Department issued a statement [PM/300 - INQ000103687 (DoH ref: PM0110)] stating that:

> *"both sides have reiterated their commitment to protecting staff and following the expert advice on infection control, working jointly to ensure the provision of appropriate PPE to the frontline, and to maximising the contribution that valued home care workers are making to those who are vulnerable. In addition, the Department made clear: that the sector must be viewed as an equal partner in the battle against Covid-19; that the Department would*

support recruitment to the sector, including through minimising burdens and speeding up pre-employment checks; and, that specific support would be in place for the sector, including to help ensure financial stability. All those involved agreed on the need for ongoing partnership and close liaison during the extremely challenging situation".

486. To help streamline communication the Department ensured that all communications were issued through the Regulation and Quality Improvement Authority to the Care Home sector, given their comprehensive list of registered homes. Relevant guidance was published on both the Public Health Agency and the Departmental website.

487. The Health and Social Care Board were also asked by the Department to meet regularly with Care Home sector representatives to address more detailed operational matters which were often raised.

Data and Information on Care Homes

488. The Department was mindful of the need to provide timely and robust information to the public about the impact of the pandemic in care homes. The reporting of deaths in Care Homes was provided by the Northern Ireland and Statistical Research Agency and in the Department's public dashboard, which also provided a wide range of information concerning the impact of the pandemic on the community across NI. This was supplemented by internal management information which gave a comprehensive, daily overview of capacity and issues facing Care Homes across NI and was used to identify targeted interventions by Health and Social Care Trusts and the Regulation and Quality Improvement Authority.

489. On 14 April 2020 [PM/231 - INQ000103692 (DoH ref: PM0115)], the Minister welcomed the commitment by the NI Statistics and Research Agency (NISRA) to publish statistics on deaths and suspected deaths in Care Homes related to Covid-19.

490. In a further statement [PM/301 - INQ000103711 (DoH ref: PM0166)] on 29 May 2020 the Minister commented on the weekly bulletin produced by NISRA, welcoming the fact that NISRA's weekly bulletin now contained a more detailed breakdown of information in relation to deaths of Care Homes residents. The Minister

had corresponded with NISRA prior to this, and had specifically requested this additional information to be included in the bulletin, in the interests of greater transparency. The Minister stated that the Department's daily statistical dashboard also included more information in respect of Care Homes.

491. The Minister also referred to reporting deaths in care homes in his opening statement to the NI Assembly's Ad Hoc Committee on 14 May 2020 [PM/232 - INQ000103679 (DoH ref: PM0101)] when he informed members that the Regulation and Quality Improvement Authority were reporting weekly figures with regard to the numbers of deaths in nursing and residential Care Homes. The Minister advised that the latest figures, when compared to the same period during both 2018 and 2019, indicated that the number of deaths was falling across the sector, with spikes reported around 21 and 27 April 2020.

492. The Regulation and Quality Improvement Authority also provided the Department with a rolling assessment of deaths which had been alerted to it in line with statutory responsibilities, as compared to previous years. This allowed the Department to assess the level of excess deaths across the sector. The Regulation and Quality Improvement Authority also provided this data, broken down by care home so that the Department could identify Care Homes, which had the highest levels of excess deaths and consider any trends or relevant factors and whether any interventions were needed.

493. The Regulation and Quality Improvement Authority also provided the Department with regular reports which provided intelligence from their Service Support Team. This was developed over time, and Care Homes were requested to provide a daily return to the Regulation and Quality Improvement Authority setting out key information. These reports from the Regulation and Quality Improvement Authority were shared with the Department.

494. The daily Regulation and Quality Improvement Authority returns contained individual Care Home information on bed status (occupancy levels), Covid-19 status (whether in outbreak or not), PPE and workforce status and any testing issues from those homes that made returns. The data in the Regulation and Quality Improvement Authority reports allowed the Department to assess available beds across the region; any impact on staff; and a number of other key issues.

495. The weekly Ministerial dashboard was based on the Regulation and Quality Improvement Authority's daily return and set out RAG (red, amber, green risk) ratings in respect of cumulative data supplied by the Care Homes against PPE issues, Workforce concerns and cleanliness of the Care Home concerns.

Rapid Learning

496. The Department was committed throughout the pandemic to learning lessons from the evolving situation within Care Homes and used this knowledge to further strengthen its response. The following paragraphs provide further information about the approach to rapid learning.

497. On 2 June 2020 [PM/252 - INQ000103701 (DoH ref: PM0127)] the Minister announced that a Rapid Learning Initiative was underway, to identify lessons from Care Home experiences of Covid-19. This initiative was designed to obtain input from the Care Home sector and from across the Health and Social Care system.

498. On 17 June 2020 [PM/302 - INQ000103712 (DoH ref: PM0169)] the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into Care Homes. He had asked the Chief Nursing Officer to co-design this new framework in partnership with the Care Home sector for the provision of clinical care. This framework would include examining how the Department would expand nursing, medical and multidisciplinary support, clinical leadership and specialist skills in collaboration with care home staff, building on the important role of GPs in Care Homes.

499. On 24 June 2020 the Minister announced that a new group had been established to learn from the Care Home experiences of Covid-19 [PM/303 - INQ000103713 (DoH ref: PM0170)]. The group was chaired by the Deputy Chief Nursing Officer and included representation from the independent care home sector, the Health and Social Care system and the Royal College of Nursing. The Group was directed to take forward the Rapid Learning Initiative on Care Home experiences.

Domiciliary Care and Supported Living

500. The Department and the Public Health Agency published Covid-19 Guidance for Domiciliary Care in NI [PM/304 - INQ000353600 (DoH ref: PM0414)], [PM/305 -

INQ000353606 (DoH ref: PM0437)] on 17 March 2020. This guidance was revised and updated to reflect developments and was reissued on 10 April 2020 [PM/306 - INQ000120749 (DoH ref: PM0172)], [PM/307 - INQ000120750 (DoH ref: PM0173)]. The guidance provided advice on areas such as steps to maintain delivery of care, the use of PPE and infection and prevention control measures, testing for care workers, and providing care in Covid-19 positive scenarios. The guidance continued to be reviewed and updated throughout the pandemic with input sought from professional staff within the Department, the Public Health Agency, the Regulation and Quality Improvement Authority and the independent provider sector.

501. Commenting on the publication of the revised guidance [PM/308 - INQ000120751 (DoH ref: PM0174)] on 10 April 2020, the Department's Chief Social Worker said:

> *"there has been a lot of focus on the idea that some jobs are key and the people who do them are key workers. Let there be no doubt that care workers fall into that category. Regardless of who employs them, we must recognise them as all being members of the health and social care family. And as members of that family, they must have the same access to PPE, testing and advice as HSC Trust staff in line with published guidance. There can be no distinction in this regard between those directly working for Trusts and those who work for organisations on behalf of those Trusts. We have to be as one."*

502. In August 2020 the Department issued 'Coronavirus (Covid-19): Northern Ireland Guidance for People Receiving Direct Payments' [[PM/309 - INQ000120752 (DoH ref: PM0175)]. This guidance set out principles to underpin the decision-making process around Direct Payments throughout the Covid period, and clarified the specific actions required from the HSC Trusts as well as those in receipt of direct payments. The guidance included a number of temporary flexibilities for the Covid period which included the possibility of employing a family member as a carer.

503. The Department published bespoke Supported Living Covid-19 Guidance on 21 October 2020 [PM/310 - INQ000130358 (DoH ref: PM0178)], and following Ministerial approval this guidance was revised and updated in December 2020 and June 2021 to reflect developments [PM/311 - INQ000137391 (DoH ref: PM0179)]. Prior to the publication of this guidance, providers used existing residential care and

domiciliary care guidelines to manage infection risk in their respective settings. This presented some challenges due to the diversity of schemes, clients and services operating in supported living schemes, which presented a varying level of Covid-19 risk.

504. The supported living guidance was developed following a process of engagement with key stakeholders, including the Health and Social Care Board, Health and Social Care Trusts, and the independent sector including Independent Health Care Providers and the Association for Real Change NI to understand better the challenges faced by providers to date and co-produce solutions that enabled a shift towards greater flexibility informed by risk-based assessment for supported living providers. Social work and nursing professional colleagues provided input specific to supporting those with learning disabilities who were supported via shared care arrangements.

505. Following approval, follow up engagement sessions were scheduled with the independent sector to further refine guidance and to co-design an approach to enable visiting in supported living settings. The guidance also set out the position on PPE, Testing and Financial Support, dependent on the type of supported living funding arrangement (i.e. solely or jointly commissioned schemes). At an operational level, providers were directed by the guidance to identify household bubbles and undertake risk-based assessments to inform local decisions and implementation. Furthermore, a number of infection and prevention control recommendations were provided, recognising that some clients may have needed to be supported to self-isolate.

506. During 2020/21, a number of financial support initiatives were established by the Department for independent domiciliary care providers to support them through the pandemic. Substantial financial support packages were put in place, alongside an income guarantee. The Department took an early decision in March 2020 that HSC Trusts should make available PPE to independent sector domiciliary care providers, without charge. Procurement of PPE was centralised through the Business Services Organisation and supplied to providers. Cumulatively, from the start of the pandemic until the end of September 2022, over 131m items of PPE have been provided to Independent Sector Domiciliary Care Providers with an estimated value of approximately £41m.

507. On 5 May 2020, the Department wrote to Health and Social Care Trusts [PM/312 - INQ000120753 (DoH ref: PM0180)] confirming arrangements for payments to Independent Domiciliary Care Providers; with details of the scheme's arrangements subsequently communicated to the relevant providers. From April 2020 until the end of June 2020 under these arrangements, providers had their income supplemented to a level that was 100% of an average of the three months prior to the pandemic. In return for this support providers were expected to ensure workers were paid at least 80% of normal earnings above the Statutory Sick Pay when on sick leave for reasons related to Covid-19. These arrangements were subsequently extended until the end of October 2020 via further correspondence [PM/313 - INQ000120754 (DoH ref: PM0181)] and [PM/314 - INQ000120755 (DoH ref: PM0182)], and ended on 31 October 2020. This income guarantee was also extended to supported living providers for the duration of the scheme.

508. Separately, in recognition of the additional costs being faced by providers due to increased measures necessary to operate during the pandemic, a Fund of £5m was established. This fund provided for additional costs, as a direct result of the Covid-19 pandemic, which had been incurred by domiciliary care providers between 1 March 2020 and 31 March 2021. Eligible costs to be provided for from the fund included: PPE; sick pay; additional staffing costs; additional staff recruitment and training costs; other staff related costs; IT; and legal and professional fees. [PM315 - INQ000148762 (DoH ref: PM0183)], [PM/316 - INQ000353601 (DoH ref: PM0418)]

509. A further fund [PM/317 - INQ000130359 (DoH ref: PM0184)], [PM/318 - INQ000353605 (DoH ref: PM0436)] of up to £5.2m was set up for independent sector providers of Health and Social Care Trust commissioned Adult Social Care services, to allow claims for additional costs which had been incurred due to Covid-19, between 1 April 2020 and 31 March 2021. The scheme allowed providers to claim for areas such as increased PPE and cleaning costs, IT, additional staff costs, and management overheads.

510. In May 2020, the Department issued a direction [PM/319 - INQ000120756 (DoH ref: PM0185)] to Health and Social Care Trusts to provide PPE to all supported living providers, including those not in receipt of health funding, to provide sufficient time for the Department for Communities and the NI Housing Executive to establish supply lines to non-jointly commissioned supported living providers. This provision

was subsequently extended at the request of the Department for Communities [PM/320 - INQ000130361 (DoH ref: PM0186)].

511. In October 2020, the Department and the Department for Communities developed a financial support package [PM/321 - INQ000130362 (DoH ref: PM0187)] to enable providers to better respond to the increased costs of delivering services throughout the pandemic. The Department's contribution was £1.2 million per annum, which continued into 2022/23. The financial package mirrored that of Care Homes in terms of eligibility and scope. The additional funding was made available to cover additional costs associated with the following categories of expenditure faced by Supported Living providers: PPE; staffing and associated overheads; compliance with Infection Prevention and Control guidelines; testing administration; and responding to emerging needs. This was agreed as a wider package for Care Homes, domiciliary care and supported living to ensure parity across sectors. The Northern Ireland Housing Executive administered the additional covid-19 Costs claimed by Jointly Commissioned Supported Living Providers during the pandemic. This was to avoid duplication of funding, prevent fraudulent claims and improve the customer experience.

512. From 26 March 2020, the Interim Protocol for Testing for Covid-19 prioritised frontline care staff in the community (including Health and Social Care Trust and non-Trust employed staff) for Covid-19 testing if they were symptomatic.

513. Recognising that some service users living in a supported living setting/ sheltered accommodation facility may be at greater risk of infection in view of their age and/or underlying health conditions, the Department (in May 2020) introduced Covid-19 testing arrangements for supported living settings with a potential cluster or an outbreak (2 or more cases) of Covid-19. The Health Protection Team in the Public Health Agency is responsible for conducting risk assessments and, as part of those risk assessments, all staff and residents are tested for Covid-19 where appropriate.

Adult Day Services & Short Breaks

514. In March 2020, HSC Trusts informed the Department of Health and service users that adult day services, inclusive of buildings-based day care and community-based Day Opportunities, would be stood down as part of a series of measures to

reduce community transmission of Covid-19. While this was not a regional decision, each HSCT adopted a consistent approach to the closure of day services. In addition, short breaks/respite services were stood down for general use, inclusive of statutory facilities and beds in adult residential care.

515. While these services cut across multiple programmes of care, they are primarily used to meet social care needs for people with learning disabilities and their families. Therefore, it was anticipated that closure of these services would have an adverse impact on the mental health and wellbeing of service users, which would be compounded by isolation throughout lockdown.

516. The Department rapidly established a regional forum to convene the Learning Disability (LD) Assistant Director, policy officials and SPPG, to meet on a weekly basis, to further explore the impact of Covid-19 on service users and identify mitigations. While no specific assessment was carried out for learning disability, this forum provided the opportunity to identify risks and ensure they were escalated to the Department.

517. Throughout March until June 2020, adult services and short breaks remained closed, although several emergency placements were made to avoid family breakdown. Trusts advised the Department that prior to service closure, several families had withdrawn their loved ones from care services due to the growing concern throughout March as Covid-19 transmission rates increased.

518. Throughout the closure period, the Department was advised on the following risks:

- Risk of serious illness/death – The leading cause of death for people with learning disabilities prior to the pandemic was respiratory illness, which suggested that they were at increased risk of adverse outcomes from Covid-19. Therefore, throughout the initial and subsequent waves, HSC providers placed a priority on Infection Prevention and Control.

- Cognition and communication – The Department was aware that people with learning disabilities may present atypically due to underlying limitations in how they understand their symptoms and their environment. In addition, people with learning disabilities typically

have communication challenges, which present risks in identifying service users that may require hospital admission until a late stage. In response, the Department alongside the Public Health Agency, provided web materials on the pandemic, symptoms and activities to maintain mental health and wellbeing.

- Mental health and wellbeing – People with learning disabilities are dependent on regular daily activity to meet therapeutic, sensory and recreational needs, which are typically met through the provision of day services. The closure of services had an impact on the wellbeing of service users and their families, which inevitably translated into a growing number of complaints to the Department. In response, HSC Trusts delivered a range of mitigations including day activity packs for the home, increased user of digital platforms (e.g. Zoom) to keep service users connected, and regular check-ins via social workers to identify placements at risk of breakdown. In a limited number of cases, day services and short breaks were restored for service users at risk of family breakdown.

519. In June 2020, HSCB led a regional exercise to remobilise day services and short breaks, which largely initiated re-opening of services across all Trusts, on a phased basis, by July 2020.

520. Throughout this period, updates to the Minister were provided across the entirety of social care provision. Specific to LD Services, the Minister received two briefings in May and June 2020 in response to correspondence cases from Carla Lockhart MP [PM/322 - INQ000353610 (DoH ref: PM0386)] and Diane Dodds MLA [PM/323 - INQ000325174 (DoH ref: PM0387)]. Following the phased re-opening of day services in July 2020, the volume of correspondence and Assembly Questions increased significantly, providing regular opportunities to update the Minister on the issues experienced by people with learning disabilities.

SECTION J: MENTAL HEALTH POLICY

521. In response to the pandemic, the functions in the Departmental Social Services Policy Group's Mental Health and Capacity Unit were expanded in mid-March 2020 to include emotional wellbeing and the mental health response to Covid-

19. To support this work, a number of existing policy groups were reconstituted, while new groups were established.

522. For example, the existing Adult Mental Health Sub-Group, which covered policy and operational cooperation for adult and child mental health services, was strengthened in response to the pandemic. This group was co-chaired by the Head of the Mental Health and Capacity Unit, with effect from 19 March 2020, and the HSCB's Programme Lead. The membership consisted of representatives from the HSCB, the Public Health Agency and the HSC Trusts. The group adopted enhanced decision making powers for regional service stability [PM/324 - INQ000120757 (DoH ref: PM0188)]. Issues were considered and recommendations proposed by the members covering a wide range of matters, including changes to service provisions, changes to protocols and measures required to ensure mental health services could be delivered during the pandemic. This included considerations such as temporary legislation, face mask rules in mental health hospitals, social distancing in mental health settings and visiting rules for mental health wards. The Head of the Mental Health and Capacity Unit provided Departmental decisions on the recommendations. If required, approval for decisions was sought from either the relevant Director or Minister or through the Health Gold structure. The Group met twice a week until May 2020 when the frequency was reduced to once a week and further to meetings once a fortnight.

523. A Mental Health and Resilience Strategic Working Group was established on 10 April 2020 [PM/325 - INQ000120758 (DoH ref: PM0189)] which reported into Health Gold. The Strategic Working Group was chaired by the Department's Director of Mental Health, Disability and Older People and was initially guided by a Mental Health and Resilience Strategic Plan [PM/326 - INQ000130393 (DoH ref: PM0279)], which became part of the Department's Covid-19, Response Plan. The objectives of the Working Group were to: develop a plan to mitigate the psychological impact of the pandemic on the general public and key groups; oversee progress in this respect; support the Mental Health and Emotional Wellbeing Silver Cell in taking forward key actions; ensure linkages across the Department, other NI departments and UK four nations; secure additional resources as required; and consider lessons learnt. From 22 May 2020, the Strategic Working Group became a decision making group for decisions escalated by the Adult Mental Health Sub-Group.

524. In mid-March 2020 a Covid-19 UK Engagement group for mental health, learning disability and autism was constituted by the Department of Health and Social Care. The purpose of the group was to share contacts and information on Covid-19 response actions and identify opportunities for learning and/or collaboration. The group met virtually on an ad-hoc basis between March and July 2020 to discuss particular topics, such as public health messaging, digital interventions, and recovery planning. The Department attended these meetings. No decisions were taken at these meetings, but rather they were used to build relationships and share information, ideas, and expertise. The discussions at these meetings informed the Department's decision making to some extent as some of the data and experiences shared informed work that was taken forward by the Silver Emotional Wellbeing Cell and the Mental Health and Resilience Strategic Working Group. For example, planning for the use of the 'Silvercloud' digital mental health platform and research on mental health and Covid-19. [PM/327 - INQ000114848 (DoH ref: PM0190)].

525. In response to concerns relating to the public health guidelines which placed a restriction on travel and exercise outside the family home, the Department was aware, through stakeholder engagement, that this restriction had a severe impact on the emotional health and wellbeing of autistic people and their families. Many autistic people are reliant on routines and familiar places to manage stress which may emerge as a result of their condition. Mindful of this, the Department worked with stakeholders, such as community and voluntary organisations, Health and Social Care and with the Police Service of Northern Ireland to present clarity and flexibility in adhering to this restriction. Additionally, measures were also taken through the provision of a letter, which issued to individuals and families through their respective HSC Trust, and could be presented, as required, should they need to leave or travel from their home additional times a day to accommodate familiar routines or places to support their mental health. The Department also worked with stakeholders to co-ordinate a series of resources, for example managing anxiety, which were published on the PHA and Department of Health websites [PM/328 - INQ000360977 (DoH ref: PM0408)], [PM/329 - INQ000360978 (DoH ref: PM0409)].

526. As the closure of schools and educational establishments resulted in many of the familiar routines and supports being removed for children with autism, learning disability or complex needs, the Department of Health and Department of Education established a joint multi-disciplinary and multi-agency forum with relevant staff across the Public Health Agency and the Education Authority to deliver an integrated

support programme for vulnerable children and families throughout the pandemic. This included special school principals and was chaired jointly by health and education.

527. The Department's officials met with counterparts in the Health Service Executive (Republic of Ireland) on a few occasions to discuss issues of mutual interest, for example, digital mental health support and the mental health Covid-19 response to the pandemic. At these meetings, information was shared which informed work within the Silver Emotional Wellbeing Cell and the Mental Health and Resilience Strategic Working Group, most specifically in relation to ongoing work on digital mental health support [PM/330 - INQ000114849 (DoH ref: PM0191)].

528. The Department also engaged indirectly with Independent Sector mental health groups such as Inspire Wellbeing and Action Mental Health through the Silver Mental Health and Emotional Wellbeing Cell of which both organisations were members. Inspire Wellbeing were also partnered with the Department for Communities on a range of work to support communities, and also linked with the Mental Health and Resilience Strategic Working Group via the Department for Communities membership on the Working Group.

529. In April 2020, the Mental Health and Emotional Wellbeing Silver Cell agreed to carry out a review of existing research relating to the impact of the pandemic on the mental health and emotional wellbeing of the general population and those with additional needs. The work continued over a number of weeks and included the establishment of a Research/Impact sub-cell which was chaired by the HSCB psychiatry lead/chair of the Trauma Network. The sub-cell produced a Rapid Review, the purpose of which was to consolidate the research, knowledge and evidence on the impact of Covid-19 on key areas of mental health and emotional wellbeing and the likelihood of new inceptions of mental illness. It included recommendations for ameliorating these, including prevention, early intervention and recovery, as well as priorities for further research.

530. The Rapid Review helped to inform work carried out by the Mental Health and Emotional Wellbeing Silver Cell, and was published on the Department's website on 31 July 2020 [PM/331 - INQ000325175 (DoH ref: PM0388)].

531. In addition to the Rapid Review, the Department worked with the Mental Health Foundation and Queen's University Belfast to produce the International Policy Guidance and Responses to Covid-19 Mental Health Recovery Rapid Review, also in July 2020. [PM/332 - INQ000325176 (DoH ref: PM0389)]. The main aim was to identify, analyse and present evidence to inform the response to mental health needs arising from, and/or being exacerbated by, the pandemic. The review addressed issues in relation to Covid recovery and identified key at risk groups including people with pre-existing mental health problems and people with disabilities.

532. The International Policy Guidance and Responses to Covid-19 Mental Health Recovery Rapid Review identified, analysed, and presented evidence to inform the response to mental health needs arising and/or being exacerbated by the Covid-19 Pandemic and examined the international evidence beyond the UK and Ireland. It recognised that the pandemic had led to a sharp increase in mental health problems and that the delivery of mental health services changed considerably during the crisis, with lockdown and social distancing measures halting many face-to-face services and in-patient care. It noted that mental health services at a community level, while also critically impacted, appeared to have been able to adapt more quickly. It also recognised that some of the services which were most agile to respond were those co-designed and co-produced by service users. It pointed to a universal call for mental health services to be prioritised, invested in, and be at the forefront of every country's response to and recovery from Covid-19 noting that taking urgent action could help prevent mental health problems and help establish more effective support systems.

533. Some of the key points highlighted in the report are summarised as follows:

- That commentators had started to think about the opportunities for change as a result of the innovative changes to service provision and the wider societal issues that the impact of Covid-19 had further highlighted.
- There was potential to harness opportunities that had emerged from the community response generated during the crisis in order to promote a community-based healthcare model that is more sensitive and responsive to the needs of the local population.
- There was a need to map and model what is available locally to understand local demand and build and strengthen a collaborative inter-agency response to meet these needs.

- That the community response to the pandemic had strengthened the role that lived experience and co-production must play in the design, delivery and monitoring of services.
- The need to acknowledge the importance of good quality data, the need for greater attention to be paid to the promotion and prevention of good mental health and the need for public health messaging that is clear, concise, trustworthy and accessible to marginalised groups.
- With mental health and wellbeing pushed to the forefront of everyone's consciousness during the pandemic, there was a (time-limited) opportunity to help to tackle some of the stigma surrounding mental health and to promote early help-seeking.
- The need to consider the limits and benefits of digital provision in the delivery of mental health services.
- The need for a 'seamless' relationship between physical and mental health in the delivery of care.

534. The Mental Health and Resilience Strategic Working Group (and the Silver Cell) fed directly into Gold Command, therefore the needs of this group of users were regularly considered at top decision-making levels.

535. The Department provided input to The Executive Office regarding the mental health impact of restrictions. The data, compiled together with the HSCB Mental Health impact cell and academic research conducted by the Mental Health Foundation in cooperation with the Department, detailed the impact of the pandemic on those with existing mental ill health, children and young people, older people, rural populations and vulnerable populations. [PM/333 - INQ000360972 (DoH ref: PM0390)].

536. Covid-19 Mental Health updates were regularly provided to the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention, which was established in summer 2020. See exhibit references [PM/334 - INQ000360973 (DoH ref: PM0391)],][PM/335 - INQ000360974 (DoH ref: PM0392)].

537. An Executive paper outlining the response to psychological wellbeing and good mental health during and after the pandemic, and the creation of a Mental Health Champion, was shared on 23 April 2020. [PM/336 - INQ000360976 (DoH ref:

PM0393)]. As outlined in paragraph 544 below, the Department developed and implemented a number of initiatives, the most notable being the Mental Health Action Plan which included a Covid-19 Mental Health Response Plan. [PM/337 - INQ000114864 (DoH ref: PM0204)] and [PM/338 - INQ000114865 (DoH ref: PM0205)]. The overarching aim of the response plan was to increase the psychological wellbeing and good mental health for the population in Northern Ireland by focussing on seven strategic themes that were identified to respond to the impact of the pandemic. These themes included coordinated Mental Health and resilience to Covid-19, provision of advice, information and support, evidence-based support and interventions, and service realignment and business post-pandemic.

538. The Research/Impact Sub Cell also produced other documentation to support the work of the Mental Health and Resilience Strategic Working Group and the Mental Health and Emotional Wellbeing Silver Cell, including a paper on the impact of Covid-19 on severe mental illness presentations [PM/339 - INQ000130363 (DoH ref: PM0193)]. This research helped to inform the work of mental health services in surge and rebuilding planning.

539. From May 2020, the Mental Health and Resilience Strategic Plan was expanded to include support for core mental health services, business continuity planning, and service realignment post-pandemic. A schematic outlining relationships and reporting arrangements is provided at exhibit [PM/327 - INQ000114848 (DoH ref: PM0190)]. The Mental Health Strategic Working Group met on a weekly basis until mid-June 2020, when it moved to fortnightly. Participant organisations included: the Department, HSCB, PHA and the Department for Communities.

540. As part of the wider response to the first wave of the pandemic, the Department commenced the mental health and mental capacity provisions of the Coronavirus Act 2020 to ensure business continuity. A key element of this work involved relaxing some safeguards set out the Mental Health (NI) Order 1986 and the Mental Capacity Act (NI) 2016 to facilitate a wider pool of people to carry out certain functions and extend the time periods to make decisions.

541. Notable examples from this period included changing the time period relating to the need to obtain a second opinion for continued medication from three to six months and emergency legislative amendments to the Mental Capacity (Deprivation

of Liberty) (No 2) Regulations (NI) 2019, changing the technical arrangements relating to deprivation of liberty safeguards. [PM/340 - INQ000114854 (DoH ref: PM0195)], [PM/341 - INQ000120716 (DoH ref: PM0109)]

542. Guidance to the temporary changes to mental health and mental capacity legislation was provided in two temporary, statutory codes of practices [PM/342 - INQ000114862 (DoH ref: PM0197)] and [PM/343 - INQ000114863 (DoH ref: PM0198)].

543. Other notable legislative changes made during this initial wave included an amendment to Article 64 of the Mental Health (Northern Ireland) Order 1986 to change the time period relating to second opinion for continued medication from three to six months, and emergency legislative amendments to the Mental Capacity (Deprivation of Liberty) (No 2) Regulations (NI) 2019, changing the technical arrangements relating to deprivation of liberty safeguards. [PM/340 - INQ000114854 (DoH ref: PM0195)], [PM/341 - INQ000120716 (DoH ref: PM0109)]

544. The Department also developed and implemented a number of plans and initiatives aimed at addressing the adverse impact on people's mental health and wellbeing during this period. Most notably, this work included publishing a Mental Health Action Plan, which also comprised a Covid-19 Mental Health Response Plan. Much of this work helped to shape and influence the development of the new ten-year Mental Health Strategy, launched by the Minister in June 2021. [PM/337 - INQ000114864 (DoH ref: PM0204)] and [PM/338 - INQ000114865 (DoH ref: PM0205)]

SECTION K: FAMILY AND CHILDREN'S POLICY

545. The Department's Family and Children's Policy Directorate has responsibility for the regulation of childcare, including the registration and inspection of provision. The Department shares responsibility for childcare policy with the Department of Education (Northern Ireland), which has lead responsibility for childcare strategy (including sufficiency of provision). Family and Children's Policy Directorate also has policy responsibility for child protection, children who are looked after, care leavers, and adoption.

546. As a consequence of the pandemic, a response was required in relation to all areas of Family and Children's Policy Directorate policy, principally through the provision of guidance, changes to the relevant statutory framework to provide greater operational flexibility and the provision of financial support. This necessitated the redeployment of some staff within the Directorate and the temporary cessation of most routine policy development work.

547. On 13 March 2020 the Director of Social Care and Children (HSCB), wrote to the Deputy Secretary of the Department's Social Services Policy Group PM/344 - INQ000137416 (DoH ref: PM0280)], advising that the HSCB anticipated that, as the Covid-19 pandemic escalated, the pressures across children's social care services would rise significantly. This would place heavy and changing demands on services and staff, significantly reducing staff availability due to illness or caring responsibilities.

548. To address the predicted staffing pressures and enable prioritisation of key tasks and appropriate workforce planning, the Director of Social Care and Children (HSCB) requested the authority to stand down or defer specified areas of responsibility across children's social care. To support this request, the HSCB also provided a draft Surge Plan for children's services [PM/345 - INQ000137417 (DoH ref: PM0281)], which set out a range of proposed actions to be taken depending on the extent of staff absences in children's services. The predicted impacts which informed the plan were based on the assumptions outlined in the HSCB's wider HSC system Surge Plan.

549. The Surge Plan for children's social care was framed around three anticipated surge levels – green (10-20% staff absence), amber (30-40% staff absence) and red (50% staff absence) – and the proposed actions to be taken in each scenario. The Department indicated on 18 March 2020 that it was content for the Surge Plan to be executed. On 23 March 2020, the Department provided a response PM/346 - INQ000130394 (DoH ref: PM0282)] addressing each area in relation to which the HSCB had requested authority to stand down or defer work. Authority was not granted in every case. A Regional Action Card [PM/347 - INQ000130395 (DoH ref: PM0283)] was developed to support the Plan.

550. In response to the challenges facing childcare providers and keyworker parents at the beginning of the pandemic, officials from the Department and the

Department of Education jointly briefed their Ministers on 30 March 2020 on the need for a package of financial support. Therefore, starting in March 2020, financial support and detailed infection prevention and control guidance was provided to the childcare sector. A bespoke 'Approved Home Childcare Scheme' was developed at pace by the Department, which enabled day care staff to provide childcare to children within the family home. Written guidance for group childcare providers and childminders was published regularly by the Department, informed by the public health advice at any particular point in time. By October 2021, the Department had issued 12 versions of guidance for group settings, and 13 versions of guidance for childminders.

551. The Department worked with the Department of Education to design the first childcare financial support scheme. The Business Services Organisation was responsible for running the scheme, which involved accepting applications and making payments, on the basis that it had the capability to do this quickly. Further funding schemes were managed fully by the Department of Education.

552. The Department and the Department of Education established a Childcare Sector Reference Group with key sectoral representatives to support the implementation of the Covid-19 Childcare Financial Support Schemes. This group also informed decision-making in relation to the recovery of the childcare sector in accordance with the Executive's Covid Recovery Plan.

553. The Department led on a cross-departmental Covid-19 Vulnerable Children and Young People's Plan [PM/348 - INQ000130396 (DoH ref: PM0284)], which was produced in co-operation with the Departments of Education, Justice, Communities and the Economy. The Plan was scrutinised by the Health and Education Assembly Committees and approved by the NI Executive.

554. The Department worked with the Department of Education, the Public Health Agency and the Education Authority to agree a Vulnerable Children and Young People's Contingency Framework [PM/349 - INQ000130364 (DoH ref: PM0194)], [PM/350 - INQ000130397 (DoH ref: PM0285)], [PM/351 - INQ000130389 (DoH ref: PM0243)], [PM/352 - INQ000130390 (DoH ref: PM0245)], [PM/353 - INQ000130415 (DoH ref: PM0350)] to ensure that effective education and associated health and social care supports were in place for vulnerable children and young people in circumstances where Covid-19 related restrictions affected access to schools.

555. The Children's Social Care (Coronavirus) (Temporary Modification of Children's Social Care) Regulations (Northern Ireland) 2020 [PM/354 INQ0000 (DoH ref: PM0286]were made in May 2020 to support emergency arrangements enabling HSC Trusts, voluntary adoption agencies and independent foster providers to undertake specified statutory functions within slightly longer timescales or in different ways. These bodies were required to comply with accompanying Departmental guidance and act in accordance with public health requirements. Their initial operational period of 6 months was extended by statutory rule to 12 months, with the regulations expiring in May 2021. Monthly monitoring reports, indicating the extent to which the flexibility provided by the temporary modifications was being relied upon, were produced during the period within which the Regulations were in operation and submitted to the Minister for approval before being shared with the Assembly Health Committee and stakeholders. Details of the regulations, versions of guidance and monitoring reports issued, including dates of issue, are included in the accompanying index PM/355 - INQ000130387 (DoH ref: PM0238)], [PM/356 - INQ000137420 (DoH ref: PM0308)], [PM/357 - INQ000137421 (DoH ref: PM0309)], [PM/358 - INQ000137422 (DoH ref: PM0310)], [PM/359 - INQ000137423 (DoH ref: PM0311)], [PM/360 - INQ000145675 (DoH ref: PM0312)], [PM/361 - INQ000137424 (DoH ref: PM0313)], [PM/362 - INQ000145676 (DoH ref: PM0314)], [PM/363 - INQ000137425 (DoH ref: PM0315)], [PM/364 - INQ000145677 (DoH ref: PM0316)], [PM/365 - INQ000137426 (DoH ref: PM0317)], [PM/366 - INQ000145678 (DoH ref: PM0318)], [PM/367 - INQ000137427 (DoH ref: PM0319)], [PM/368 - INQ000145679 (DoH ref: PM0320)], [PM/369 - INQ000137428 (DoH ref: PM0321)].

556. The Department implemented new temporary data collection arrangements which initially involved collecting data on a weekly basis and from January 2022 on a monthly basis. This data included: the number of child protection referrals to children's services; the number of children on the child protection register; and the number of looked-after children. The data was used to identify emerging issues and needs.

557. The Department developed guidance for the management of Covid-19 in the following settings: Residential Children's Homes; Foster Care and Supported Lodgings; 16-21+ Jointly Commissioned Accommodation Settings; and Adoption Services.

558. That particular guidance provided advice on social distancing and public health advice in each of these settings, the use of PPE, the identification of children and young people with additional risks, the provision of education support, visiting arrangements and detailing where applicable standards could be relaxed. Details of the versions of guidance issued and dates of issue are included in the accompanying index [PM/370 - INQ000137412 (DoH ref: PM0239)], [PM/371 - INQ000145680 (DoH ref: PM0322)], [PM/372 - INQ000145681 (DoH ref: PM0323)], [PM/373 - INQ000145682 (DoH ref: PM0324)], [PM/374 - INQ000145683 (DoH ref: PM0325)], [PM/375 - INQ000145684 (DoH ref: PM0326)], [PM/376 - INQ000145685 (DoH ref: PM0327)], [PM/377 - INQ000145686 (DoH ref: PM0328)], [PM/378 - INQ000145687 (DoH ref: PM0329)], [PM/379 - INQ000145688 (DoH ref: PM0330)], [PM/380 - INQ000145689 (DoH ref: PM0331)], [PM/381 - INQ000145690 (DoH ref: PM0332)], [PM/382 - INQ000145691 (DoH ref: PM0333)], [PM/383 - INQ000145692 (DoH ref: PM0334)], [PM/384 - INQ000145693 (DoH ref: PM0335)], [PM/385 - INQ000145694 (DoH ref: PM0336)], [PM/386 - INQ000145695 (DoH ref: PM0337)], [PM/387 - INQ000145696 (DoH ref: PM0338)], [PM/388 - INQ000145697 (DoH ref: PM0339)], [PM/389 - INQ000145698 (DoH ref: PM0340)], [PM/390 - INQ000145699 (DoH ref: PM0341)], [PM/391 - INQ000145700 (DoH ref: PM0342)], [PM/392 - INQ000145701 (DoH ref: PM0343)] & [PM/393 - INQ000145702 (DoH ref: PM0344)].

559. The Department liaised on a regular basis with childcare policy officials in England, Scotland, Wales and the Republic of Ireland, which helped to inform the NI childcare policy response.

560. In relation to child protection, the Department liaised on a regular basis with safeguarding policy officials in England, Scotland & Wales. A Covid-19 Four Nations Child Safeguarding Officials Group was established and met fortnightly. It was chaired by officials in the Department for Education in England. Its primary purpose was information-sharing. Advice was also sought from the Department of Health and Social Care in relation to changes being made to vetting and barring policy in England and Wales and similarly from the Garda Vetting Bureau in the Republic of Ireland.

561. In relation to the development of guidance for residential children's homes and other settings where looked after children or care leavers live, the Department liaised informally with contacts in the Department for Education in England, as it developed its own guidance for similar settings. Officials also took account of

guidance developed by Tusla, the Child and Family Agency in the Republic of Ireland, and by the Scottish government.

562. In relation to changes to the statutory framework (as it related to the care and protection of children) in March/April 2020, officials made contact with counterparts in Great Britain and the Republic of Ireland government departments to gain an indication of the intended approach in those jurisdictions in terms of both legislation and guidance. Thereafter, officials closely examined equivalent emergency legislation and guidance published online by the other UK jurisdictions and monitored related parliamentary activity. Officials considered whether the legislative provision and guidance put in place by counterparts in other jurisdictions would be necessary or appropriate in the NI context, taking into account the particular characteristics and challenges of NI's social care system.

563. The Department's officials liaised at key points prior to and following the making of the regulations with the NI Commissioner for Children and Young People, the Children's Law Centre, the Voice of Young People in Care, the NI Human Rights Commission, Fostering Network (NI) and the British Association of Social Workers (NI). Discussions also took place with representatives of the Health and Social Care Board, the Health and Social Care Trusts, voluntary adoption agencies and the NI Courts and Tribunal Service. The detailed insight and feedback provided by these organisations informed the drafting of both the regulations and guidance. Liaison also took place with the four independent fostering organisations in NI, AccessNI and the Regulatory and Quality Improvement Authority, particularly during post-implementation monthly monitoring.

564. Information shared by the above organisations provided insight into matters such as service pressures, staff absence rates, emerging risks, localised outbreaks, and other practical challenges experienced on the ground. In turn, the Department provided these organisations with the monthly implementation reports referred to above.

565. Throughout the pandemic, the Family and Children's Policy Directorate had access to public health advice through the Public Health Agency and, if necessary, directly from the Child Support Agency. Specifically in relation to guidance for looked after children services, the Department sought advice from Senior Medical Officers in the CMO Group as well as the Public Health Agency. Drafts of the guidance were

also circulated to officials in the Department of Education for comment and advice on the provision of educational support for looked after children and their carers. The Department for Communities and the NI Housing Executive also reviewed and provided input to guidance for 16-21+ year olds jointly commissioned supported accommodation settings. The guidance was also reviewed and agreed by professional officers in the Department's Office of Social Services prior to issue. Nominated infection prevention and control nurses worked with children's homes in each HSC Trust area.

566. In addition, the Department gathered detailed monthly data from the statutory and voluntary organisations affected by changes to the statutory framework (as it related to the care and protection of children) on the extent to which the flexibility provided by the temporary modifications was being relied upon. That data informed the Department's ongoing analysis of whether the Regulations were being used proportionately and appropriately, and the extent to which their continued operation was necessary. To inform key decisions about the Regulations, the Department also relied on data on Covid-19 infection levels published daily on the Department's Covid-19 dashboard and key indicators of demand for children's services as published in weekly data, e.g. numbers of child protection referrals, children's social care referrals and the number of children in care.

567. The public health advice received from the Public Health Agency, and the Chief Scientific Adviser was used as the basis for the introduction, and subsequent relaxation, of infection prevention and control measures within the Covid-19 Childcare Guidance referenced above. For example, when viral transmission was particularly high, group childcare settings were required to care for children in small, consistently constituted groups or 'pods.

568. The Department worked with the Executive Information Service to run a social media campaign in June and July 2020 to promote Childline, the NSPCC helpline and the 24 hour Domestic and Sexual Abuse helpline. The Department provided funding to NSPCC to support a four-week awareness raising campaign in March 2021 to encourage families who needed additional support during lockdown to reach out for help at an early stage and encourage collective responsibility in continuing to report concerns regarding the safety of a child. A key element of the awareness raising campaign included a social media campaign (paid for advertisements and

organic posts[13]) involving a dedicated series of social media posts to promote local safeguarding agencies, family support and NSPCC services aimed at anyone who had concerns or needed support and to highlight the availability of free safeguarding awareness training being delivered by the NSPCC.

SECTION L: HEALTH INEQUALITIES

Coronavirus Related Health Inequalities Report

569. Epidemics of infectious disease epidemics and pandemics exacerbate and accentuate existing disparities in society, such as those associated with deprivation, ethnicity, sex, age and sexuality. The Covid-19 pandemic therefore resulted in some predictable, and some less predictable disparities in health outcomes, such as the significant age associated risk, and the risk of more severe disease in people with obesity. Some health impacts are distinct to certain infections and how the infections are transmitted. For example, some of the disparities in the Covid-19 pandemic arose due to the fact that as a respiratory pathogen, the route of transmission was airborne. This resulted in increased spread among people living in crowded households or individuals working in public facing settings with inadequate ventilation. For example, more deprived communities and younger people were disproportionately impacted by public health control measures in the short term, including closures to school and the hospitality sector. These factors are considered more fully in the CMO Technical Report Chapter 2. [PM/6 INQ000217254 (DoH ref: MMcB001)]

570. On 17 June 2020 the Department published the 'Coronavirus Related Health Inequalities Report' [PM/394 - INQ000103718 (DoH ref: PM0209)]. This report presented an analysis of Covid-19 related health inequalities by assessing differences between the most and least deprived areas of NI and within Local Government District (LGD) areas for Covid-19 infection and admission rates. The information in the report relates to the position as at 26 May 2020.

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[13] Organic posts in the context of a social media campaign, consist of free content shared on social media profiles including posts, videos, stories and more. This content can be seen by a portion of the individual's followers, people who are following relevant hashtags and the followers of anyone who shares the post.

571. The report [PM/395 - INQ000103719 (DoH ref: PM0210)] was prepared by the Department's Information Analysis Directorate following a discussion with the Permanent Secretary [PM/396 - INQ000130379 (DoH ref: PM0212)] and approval from the Minister in submission SUB-1522-2020 [PM/397 - INQ000130380 (DoH ref: PM0213)], [PM/398 - INQ000137392 (DoH ref: PM0214)]

572. The key findings from laboratory completed tests were as follows. The infection rate in the 10% most deprived areas (379 cases per 100,000 population) was a fifth higher than the rate in the 10% least deprived areas (317 cases per 100,000 population) and two-fifths higher than the NI average (272 cases per 100,000 population). The rate among females (308 cases per 100,000 population) was a third higher than males (234 cases per 100,000 population).

573. The infection rate among those aged over 65 was almost two-fifths higher in the 10% most deprived areas (1,027 cases per 100,000 population) than the rate in the 10% least deprived (750 cases per 100,000 population) and almost three-quarters higher than the NI average. While infection rates were highest in the 10% most deprived areas for under 65s, over 65s, and all ages; the 10% least deprived areas had the second highest infection rate for over 65s and all ages.

574. The rate in urban areas was 90% higher than the rate seen in rural areas, however the rate was highest in mixed urban/rural areas (398 cases per 100,000 population).

575. Of those testing positive, more than a quarter (27%) were admitted to hospital for treatment, with males (39%) being twice as likely to be admitted as females (19%), and those in the 10% most deprived areas 37% more likely to be admitted than those in the 10% least deprived areas.

576. The key findings from admissions to hospital were as follows. The admission rate for Covid-19 (confirmed or suspected cases) in the 10% most deprived areas (581 admissions per 100,000 population) was almost double the rate in the 10% least deprived areas (317 admissions per 100,000 population).

577. The rate for under 75s in the most deprived decile (369 admissions per 100,000 population) was approximately two and a half times that in the least deprived decile (150 admissions per 100,000 population). In comparison, the 75 and over rate for the most deprived decile was almost two-fifths higher than in the least deprived

decile. While deprivation was found to be an important factor of the likelihood of admission, age was found to have a greater impact. The standardised admission rate for the population aged 75 and over (2,255 admissions per 100,000 population) was 9 times that for the under 75 population (249 admissions per 100,000 population). [PM/398 - INQ000137392 (DoH ref: PM0214)]

578. With regards to social deprivation and links to Covid-19, research from NI published in the British Medical Journal (BMJ) in June 2021 supported that this was a significant factor [PM/399 - INQ000346704 (DoH ref: PM0395)].

Monitoring of 'Making Life Better' Indicators

579. The Department commissioned the Institute of Public Health in Ireland (IPHI) to provide high level monitoring of the wider evidence base in relation to the impact of the pandemic, and the measures to address it, on indictors within the overarching public health strategy for NI, "Making Life Better". The first two reports were produced in May 2020 [PM/400 - INQ000276461 (DoH ref: PM2153)], [PM/401 - INQ000276462 (DoH ref: PM2154)] and the third report in July 2020 [PM/402 - INQ000276463 (DoH ref: PM2155)]. Further reports were produced throughout 2020 and 2021, as referred to in the Department's Wave 2 corporate statement. Although these reports were not shared directly with the Minister, they were shared with senior officials within the Department and were used to inform the development of papers submitted to the Executive reviewing the coronavirus restrictions regulations. The level of detail provided in the papers to the Executive varied, for example, for some we focused on specific issues, such as physical activity and for others we summarised the evidence at a high level.

Wider health, societal and economic impacts of the regulations

580. From the second Review of the Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 [PM/403 - INQ000346705 (DoH ref: PM0399)] and thereafter throughout Wave 1 of the pandemic [PM/404 - INQ000346706 (DoH ref: PM0400)], [PM/405 - INQ000346707 (DoH ref: PM0401)], [PM/406 - INQ000346708 (DoH ref: PM0402)] and subsequent waves, the Executive papers considered not only the impact of the Coronavirus pandemic itself but also the measures put in place to control the spread of infection. The wider health, societal and economic impacts of the regulations were integral to weighing up the continuing

necessity and proportionality of the restrictions and were also part of the consideration of each individual new measure proposed. This information was supplemented by the Monitoring of 'Making Life Better' Indicators and supported by a number of pieces of work taken forward at the UK level by the Department of Health and Social Care and Public Health England, including work to examine the apparent disproportionate impact of Covid-19 on the BAME population as well as marginalised groups such as the Roma community.

581. The Public Health Agency also worked to consider the impact of Covid-19 on key public health services, and to target at-risk groups to reduce the risk of harm as far as possible.

Financial and Other support to address Health Inequalities

582. Throughout the pandemic there was specific focus on the needs of the most vulnerable. During Wave 1 this was partly reflected in the arrangements which were put in place to support the clinically extremely vulnerable. There is an accepted correlation between areas of deprivation and higher levels of ill health and the incidence of social issues.

583. Communications and Statements issued by the Department sought to raise public awareness of groups who were particularly vulnerable to the negative effects of lockdown restrictions and to highlight where support was available. An example from 18 March 2020 is a press statement from the Chief Social Services Officer in which he confirmed that updated Covid-19 guidance has been issued to the care home and domiciliary care sectors. He said: "The Department of Health, alongside other parts of Government are stepping up a major programme to ensure that vulnerable people in communities are supported. This is not something that the HSC can deliver on its own, it will require everyone in society to support this effort." And "Anyone supporting a person self-isolating, whether through an informal or formal arrangement must practice good infection control. Free online training on infection control can be accessed here: https://learningzone.niscc.info/learning-resources/96/supporting-good-infection control."

584. During Wave 1 The Department also took a number of decisions and actions which would have positively impacted on the needs of populations who were

disadvantaged in the context of health inequalities. This included decisions and actions in partnership with other departments, particularly the Department for Communities and Department of Education. This was in a context where Executive Ministers collectively agreed a number of spending allocations which would be of benefit to the same groups. Specific examples are addressed below in paragraphs (584 to 593)

585. On 9 April 2020 Executive Ministers announced a number of financial allocations to support the most vulnerable in society:

- £15.3 million had been identified to support initiatives for the most vulnerable in society including a weekly food box service for over 10,000 people, grants for older people and support for the homeless. An additional £10 million provided towards further interventions to support vulnerable members of society.
- An additional £0.4 million went to the Youth Service to support the Department for Communities' provision of food for vulnerable young people.

586. As part of the same announcement the Minister in partnership with the Education Minister outlined a package of measures, worth around £12 million, to support vulnerable children and the children of key workers. They included:

- A bespoke Approved Home Childcare Scheme aimed at enabling key workers to have their childcare needs met in their own homes;
- Enhanced support for registered childminders who provided childcare for key workers and vulnerable children;
- Support for registered daycare settings to remain open for key workers and vulnerable children in locations where key worker parents needed them most and for those settings which had been forced to close;
- Childcare advice and guidance for parents who were key workers, including a helpline; and
- Advice and guidance for registered settings and providers.

587. On the same date the Department launched a second version of its Covid-19 mobile app. The new version, which was available for downloads on Apple and Google platforms, offered improved navigation, more detailed guides, updated links to latest reports and an updated symptom checker based on latest information. It continued to help members of the public to:

- decide if they or someone they care for have the symptoms of coronavirus;

- understand the severity of their symptoms and what to do and how to cope;
- decide if they need to get clinical advice and how to access it;
- access specific advice for vulnerable members of the community; and
- get an isolation note if they are advised to self-isolate.

588. Less than two weeks later the Departments sought to widen access to the app by launching an online version of the Covid-19 NI app to help people across Northern Ireland stay informed, serving those who did not have a smartphone, but were able to use a computer or tablet device.

589. Also on 9 April 2020, the Infrastructure Minister Nichola Mallon and Agriculture, Environment and Rural Affairs Minister, Edwin Poots, put further community transport measures in place to ensure vulnerable people in rural areas isolated as a result of Covid-19 have access to vital services.

- Community transport operators were able to repurpose Dial-A-Lift services to help the most vulnerable, such as the elderly and the disabled, to access shops and services for everyday requirements.
- Instead of transporting people to services, services would be transported to the most vulnerable.

590. The Minister for Agriculture announced £200,000 had been allocated to the emergency 'Coronavirus Community Fund'. The Community Foundation NI considered applications for grants up to £10,000 to community organisations to deliver targeted practical support for the vulnerable and isolated, especially in rural areas and for those of all ages who were at increased risk due to poor mental health and wellbeing.

591. On 23 April 2020 the Department, in partnership with the Department for Communities launched a jointly funded remote interpreting service for sign language users [PM/407 - INQ000346720 (DoH ref: PM0435)]. The service enabled British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and health and social care services during the COVID-19 pandemic. The service was available 24 hours a day, 7 days a week. As part of the announcement the Minister said: "*During these very challenging times my priority continues to be protecting the wellbeing of the most vulnerable in our society. The Deaf community, in particular, face barriers to effective communication on a daily basis. This service will enable Deaf people to access vital public health information and engage with healthcare*

professionals on the same basis as hearing people. The COVID-19 public health crisis has raised awareness across Government of the importance of providing information and services that are accessible to people with sensory, physical, and learning disabilities. Work is ongoing to ensure that those in health and social care join forces with partners in the community and voluntary sector to improve accessibility for the Deaf community including translating key messages and providing a wide range of videos and documents in British and Irish Sign Language."

592. On 29 April 2020 the Minister in partnership with the Minister of Justice issued guidance on maintaining contact between parents and children during Covid-19. In the statement the Minister said "*The key consideration at this difficult time must of course be the health and well-being of children and it is important that they continue to spend time with both parents in line with contact orders, unless doing so would put the child or others at risk. The mandatory stay at home direction does not apply to children moving between households. Parents can continue to share care of their children but every family is different and I would encourage parents to work together to assess their particular circumstances. Parents should consider the child's health, the risk of infection and the presence of any vulnerable individuals in homes children may be visiting. Where parents are concerned that maintaining face to face contact would place the child or others at risk they can agree temporary changes without going back to court. Changes should be in keeping with the spirit of existing court orders may include contact taking place remotely by telephone or using online tools. Online tools will be particularly useful where contact is usually supervised and social workers will be liaising with families to help them maintain contact with children remotely during the time that direct contact is suspended.* "

593. On 18 May 2021, the Minister wrote to his Executive colleague, the Minister for Communities (Deirdre Hargey MLA), outlining that it remained of critical importance that adequate and easily accessible financial support be provided for the most economically vulnerable who are less likely to seek testing, engage with the Contact Tracing Service or to self-isolate, or to take time off work to get vaccinated, if these actions have potential to threaten their financial stability [PM/408 - INQ000346709 (DoH ref: PM0403)]. On this specific point, the Minister also sought an update on the financial support measures that were in place and also for Minister Hargey's consideration of any and all further enhancements that could be made at this time.

Revised Arrangements for the Identification of Close Contacts in Schools

594. On 9 September 2021, the Ministers for Education and Health issued a Joint Memo to the Executive outlining *Revised Arrangements for the Identification of Close Contacts in Schools* [PM/409 - INQ000346710 (DoH ref: PM0404)].

595. The Memo outlined broadly similar findings from studies across the UK that had shown that the vast majority of those identified as school close contacts and sent home to isolate during the 2020/21 school year did not go on to develop COVID-19.

596. The memo advised of a more targeted and proportionate approach, to be led by the PHA contact tracing service, therefore easing the burden on teachers and principals, which would involve asking only the very closest identified contacts – for example very close friends - to isolate and get a test. Other contacts were not to be routinely asked to isolate and book a test.

597. The Covid pandemic was very damaging to the wellbeing of children, including their mental health, as well as to their education. A combination of school closures and Covid related absences resulted in children missing out on a significant amount of school during the pandemic. As such, it was imperative that all measures and interventions were proportionate to the risk posed to children based on available evidence, and that healthy pupils missed as little time in school as possible to improve their education, mental health and well-being, and life chances generally.

598. Children from more disadvantaged backgrounds were particularly negatively impacted during the pandemic. For example, PHA analysed 18,500 close contacts in Northern Ireland which showed that children from the most disadvantaged areas were more than twice as likely to have to isolate compared to children from the most affluent areas, further exacerbating inequalities.

599. Given the relatively low risk to children at that stage of the pandemic in line with available evidence, and given the general population protection offered through high vaccination rates and the easing of restrictions in society more widely, this more

targeted approach was a proportionate response and sought to strike an appropriate balance between safeguarding children's education and wellbeing and measures to contain Covid [PM/410 - INQ000346711 (DoH ref: PM0405)]. A key driver for the changed approach was to help ensure that children who did not need to miss school, were able to attend as often as possible. This would particularly benefit those in the most deprived areas.

Vaccine

600. Reviews of the NI Vaccine uptake data in March 2021 started to identify a number of geographic areas and national/ethnic background groups which had below the NI average vaccine uptake levels. The Public Health Agency was tasked with leading this element of the vaccination programme and a number of key cohorts were identified by the PHA Health Intelligence Team as having low uptake of the Covid-19 vaccines. This included: People living in the most deprived areas; Ethnic Minority & Migrant (EM & M) Communities (estimated 90,000 population); Travellers; People who are Homeless; and Asylum Seekers.

601. The Department's Vaccine Plan consequently also included a focus on Vaccine Equity. This built further on the Department's approved interventions with Asylum Seekers, Homeless and Foreign Fishermen who had been identified as priority vulnerable groups [PM/411 - INQ000346712 (DoH ref: PM0406)].

Abortion Service

602. In 2017 the UK Government announced that it would fund, via the Government Equalities Office, abortions for women ordinarily resident in Northern Ireland, who travelled to England and Wales for this service as abortion was only available in NI in very limited circumstances. In 2018, 1,053 women travelled to England and Wales for this service. This number reduced to 1,014 in 2019 and to 371 in 2020 [PM/412 - INQ000130382 (DoH ref: PM0216)].

603. The UK Government introduced a legal duty under section 9 of the Northern Ireland (Executive Formation etc) Act 2019 to inform a new framework for access to abortion services in NI. Following this the Department started the process of scoping a project to commission abortion services from the HSC. The project was paused in early 2020 due to the need to divert staff resources to managing the response to the

pandemic. The Abortion (Northern Ireland) Regulations 2020, introduced by the Northern Ireland Office to give effect to the legal duty, came into force on 31 March 2020. Pending the commissioning and implementation of the services permitted under the Regulations, prior existing arrangements were to remain in place whereby women in NI could continue to be funded by the Government Equalities Office for travel to England and Wales for an abortion if they wished to do so until the service was commissioned locally.

604. While the new travel restrictions did not prohibit people leaving home or travelling for medical reasons, the Department recognised that they would make it difficult for women in NI to travel to England to continue to access abortion services. A telemedicine Early Medical Abortion service was made available to women in England by the Department of Health and Social Care, as a response to the potential impact of the pandemic on access to Early Medical Abortion services resulting from travel restrictions and social distancing measures in England.

605. In the period leading up to the first wave of the pandemic the Northern Ireland Office were consulting on the draft regulations. To forestall any potential adverse impact from preventing women in NI travelling to England for Early Medical Abortion services, due to the restrictions on domestic travel, the Department proposed to the Northern Ireland Office that it should consider an amendment to the draft regulations to enable women in NI to have access to the telemedicine service in England. While abortion legislation had come into effect in NI from 31 March 2020, it did not make automatic provision for a telemedicine service. The Northern Ireland Office declined this request. [PM/413 - INQ000130413 (DoH ref: PM0303)] & [PM/414 - INQ000130414 (DoH ref: PM0304)]

606. The Department, therefore mindful of the potential adverse impact on women in NI submitted a paper to the Executive on 3 April 2020 seeking agreement to commission in NI a telemedicine Early Medical Abortion service for the duration of the pandemic, similar to the service provided in England. The Department received legal advice that the commissioning of any abortion services would require prior Executive agreement under the Ministerial Code.

607. The paper was discussed by the Executive on 6 April 2020, without agreement being reached on a way forward. A further paper resubmitting the proposal was sent to the Executive on 13 May 2020, and was not tabled for

discussion thereafter. As consensus on the matter was not reached, prior Executive authority to proceed with the proposal under the terms of the Ministerial Code was not obtained. Copies of the Department's two Executive papers are contained at [PM/415 - INQ000130383 (DoH ref: PM0217)], [PM/416 - INQ000148766 (DoH ref: PM0218)] of the exhibits.

608. As the position was not resolved by the Executive, NI's five HSC Trusts introduced a non-commissioned Early Medical Abortion Service for women in NI. The CMO issued advice to the Trusts and medical professional bodies in April 2020 [PM/417 - INQ000130384 (DoH ref: PM0219)], [PM/418 - INQ000137397 (DoH ref: PM0220)], [PM/419 - INQ000114876 (DoH ref: PM0221)], [PM/420 - INQ000114877 (DoH ref: PM0222)], [PM/421 - INQ000114878 (DoH ref: PM0223)] [PM/422 - INQ000114879 (DoH ref: PM0224)], [PM/423 - INQ000114880 (DoH ref: PM0225)], [PM/424 - INQ000114881 (DoH ref: PM0226)], [PM/425 - INQ000114882 (DoH ref: PM0227)] concerning the position on abortion services. This non-commissioned service meant that no additional funding was provided for the service and women were required to travel to designated treatment centres to access the service.

SECTION M: REBUILDING OF HSC SERVICES

609. The Department's Top Management Group established a project in May 2020 to assess the impact of Covid-19 on HSC services delivery to inform the production of a 'Rebuilding HSC Services Strategic Framework'. The main impact on services was a downturn in activity resulting in increased waiting times to access services. The project aimed to prioritise the services, projects and programmes that should be resumed as Covid-19 patient numbers began to stabilise. The project also recommended changes to the HSC governance arrangements to make these as efficient as possible within the challenging situation for service delivery arising from the pandemic. The changes to the governance arrangements were also informed by the findings of an 'in-flight' assessment of the Health & Social Care service coordination in response to the pandemic [PM/426 INQ000103720 (DoH ref: PM0228)], which reviewed the Department's emergency management structures.

610. The normal governance arrangements for Health and Social Care in NI are set out in the HSC Framework Document [PM/427 - INQ000103721 (DoH ref:

PM0230)], published by the Department in September 2011, to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the Department, its HSC Arm's Length Bodies and the systems that govern their relationships with each other and the Department. The Department's Emergency Response Plan 2019 [PM/6 - INQ000184662 (DoH ref: PM5013)] sets out the governance arrangements for the Department's response to emergencies for which it had been designated lead. The Plan also sets out the arrangements and structures which underpin the Department's role in providing strategic health and social care policy advice and/or direction in support of the efforts of others, including its associated agencies and ALBs in response to emergencies for which it had been designated lead. During previous emergencies, when the Emergency Response Plan was activated, the normal governance arrangements set out in the Framework Document continued to operate during the emergency.

611. In their report the Reviewers suggested (on pages 11 and 12): "*that the Department consider if the normal governance arrangements remain suitable in the current circumstances. They do not appear to be a comfortable fit with the command & control environment that is currently operating nor with the suggested model if that was instituted*". It is the Department's view that the Reviewers were referring to the "*command and control environment*" which emanated from the Gold decision-making structures and processes set out in the Department's Emergency Response Plan during the initial months of the pandemic. The Department activated Health Gold Command on 9 March 2020. From this date the primary focus of the Department's governance of the HSC system (set out in the Framework Document) therefore changed from the oversight and management of the planning and delivery of routine health and social care services, to combining this with the planning and implementation of services designed to alleviate the impact of the pandemic on the HSC. The Gold structures and processes (set out in the Emergency Response Plan) were designed to manage emergencies with a duration of days or weeks rather than the emergency situation of months and years resulting from the Covid-19 pandemic.

612. . The routine governance arrangements generally worked well under the normal non-pandemic operating environment. Difficulties with the suitability of the normal governance arrangements (set out in the Framework Document) arose from sustaining normal governance, which operated on the basis of an annual planning cycle, alongside a command and control approach to governance (as detailed in the

Emergency Response Plan) in response to the initial dynamic fast moving months of the emergency which often required rapid decision making. Normal governance involved the administering of HSC bodies by statutorily appointed management boards, which remain ultimately accountable to the Department for the discharge of their respective functions set out in the Health and Social Care (Reform) Act (NI) 2009.The system of administration operated on the basis of an annual Commissioning Plan Direction, setting out the Minister's priorities for the delivery of services, from the Department to the HSCB which in turn produced an annual Commissioning Plan for the HSC bodies. During the period April to May 2020 the Department's Top Management Group therefore recognised that a new temporary governance model would be needed to oversee the HSC system during the period of the ongoing pandemic. This required striking a balance between the emergency governance arrangements introduced to mitigate the impact of Covid-19 on the HSC system, allowing these to be escalated and de-escalated in line with the projected trajectory of the pandemic; and modifying the normal governance arrangements for the oversight of HSC routine service delivery. This involved marshalling all available Departmental and HSC resources to work together across organisational boundaries, directed via a combination of command and control, when necessary, alongside the incremental rebuilding of routine service delivery. These new arrangements, which were stood up June 2020 at the same time as the Emergency Operations Centre was being stood down, ensured a sustainable and inclusive approach to decision-making during this difficult, protracted and unprecedented period. This temporary governance model is described in paragraphs 613 to 618 below and paragraphs 6 to 19 in the Department's Wave 2 Corporate Statement.

613. The Deputy Secretary of the Healthcare Policy Group, briefed the Minister on the outcome of the project which proposed a change in the HSC governance arrangements to introduce a new business model to oversee the recovery of HSC services, following the initial surge of the Covid-19 pandemic. [Submission dated 22 May 2020 [PM/428 - INQ000130385 (DoH ref: PM0229)]. The new business model would require amending the HSC Framework Document[14] (the Framework Document) [PM/427 - INQ000103721 (DoH ref: PM0230)] to establish new temporary governance arrangements and a new temporary Management Board. Both measures

[14] The Department produced the Framework Document, published in September 2011, to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various HSC bodies and the systems that govern their relationships with each other and the Department.

were required to facilitate and provide direction for the rebuilding of HSC services and to oversee planning of service capacity for any potential further waves of the pandemic and/or local outbreaks.

614. Officials proposed that a Memorandum [PM/429 - INQ000103722 (DoH ref: PM0231)] to the Framework Document should be published setting out the temporary changes to the governance arrangements, constituted by the establishment of the Management Board for Rebuilding HSC Services, for a period of two years with effect from June 2020 and to be kept under review. It was proposed that the two years period would be followed by a consultation on substantive and longer-term changes to the Framework Document, reflecting both learning from this period, and the dissolution of the Health and Social Care Board which was expected within this timescale.

615. The new temporary Management Board for Rebuilding HSC Services was established in June 2020 and reported directly to the Minister. It was given the responsibility for providing oversight and direction to the HSCB, Public Health Agency, the HSC Trusts and the Business Services Organisation on the implementation of the Department's 'Strategic Framework for Rebuilding HSC Services' (see paragraph 619 below). The Management Board would not exercise any other authority in relation to the statutory duties, roles, and responsibilities, as specified in the Framework Document, which the Department has delegated to the Health and Social Care Board, the Public Health Agency and a number of other HSC bodies.

616. The submissions suggested that the Management Board would be chaired by the Department's Permanent Secretary and its membership would be drawn from the Department's senior officials and other senior staff from across the HSC. The Minister could also request additional expert advice from existing Departmental external stakeholder groups, as required, on the implementation of the Strategic Framework.

617. The submission went on to recommend that the Minister should direct the Health and Social Care Board, the Public Health Agency, HSC Trusts and the Business Services Organisation that for the two year period commencing in June 2020 they were to prioritise their service planning, delivery, and deployment of

resources to stabilise and restore service delivery as quickly as possible by achieving the right balance between delivering Covid-19 and non-Covid-19 activity.

618. In pursuance of this priority the Department's HSC Commissioning Plan Direction, the Health and Social Care Board's Commissioning Plan and associated Service and Budget Agreements for the 2019/20 financial year would be rolled forward into the years 2020/21 and 2021/22 and updated to reflect Departmental budget allocations in each of these years. Individual HSC Trust Delivery Plans for 2020/21 and 2021/22 should also prioritise activity designed to stabilise and restore service delivery as quickly as possible at the level of local commissioning and through regional collaboration with other Trusts guided by the Department's 'Strategic Framework for Rebuilding HSC Services'. The performance targets set out in the Commissioning Plan Direction, Service and Budget Agreements and Trust Delivery Plans for the financial year 2019/20 would be reviewed by the Department to determine the optimum method for assessing the performance of HSC Trusts in the delivery of services during the period of the Covid-19 emergency in the years 2020/21 and 2021/22.

619. The Minister agreed to the above proposals. He also agreed amendments to the terms of reference for the Minister's attendance at the Management Board for Rebuilding HSC Services and the basis for seeking expert input to the Board in a further submission dated 5 June 2020 [PM/430 - INQ000137398 (DoH ref: PM0232)].

Strategic Framework for Rebuilding HSC Services

620. The Management Board commenced its work in June 2020 with its priority to produce a 'Strategic Framework for Rebuilding HSC Services'. This Framework set out the Department's approach to restoring services as quickly as possible, within the prevailing Covid-19 context. The Framework was accompanied by successive quarterly individual HSC Trust rebuilding plans, all of which have been published on the Department's website[15] [PM/431 - INQ000130386 (DoH ref: PM0233)]. There was a six month period where Trust rebuild plans were not published (October 2020 to March 2021) due to the severity of the pandemic at that time. The Minister approved the Strategic Framework for Rebuilding HSC Services [PM/432 - INQ000137403 (DoH ref: PM0234)]. Which was shared with the NI Executive in

[15] https://www.health-ni.gov.uk/publications/rebuilding-hsc-services

advance of publication [PM/433 - INQ000137404 (DoH ref: PM0235)], [PM/434 - INQ000137429 (DoH ref: PM0346)], [PM/435 - INQ000137430 (DoH ref: PM0347)], [PM/436 - INQ000137432 (DoH ref: PM0348)], [PM/437 - INQ000137433 (DoH ref: PM0349)], [PM/438 - INQ000120719 (DoH ref: PM0130)].

The Role of the Public Health Agency

621. In general terms the responsibility for public health policy and oversight of implementation resides with the Department, with expert advice to inform public health policy development received from a number of sources including primarily the PHA in NI. Operational delivery in in normal circumstances resides with the relevant public health body in each UK jurisdiction.

622. As with all public health bodies and agencies across the UK and internationally, the PHA faced significant and sustained challenges in its role in responding to the pandemic particularly given the intensity of the response required and its duration. The Department and the PHA had by comparison significantly less resource available to it as compared to other UK jurisdictions. At the onset of the pandemic the PHA had a number of staff vacancies and interim appointments in key roles. Recruitment challenges and planned staff retirements were also reflected in vacancies in key roles in the Department at the onset of the pandemic.

623. In anticipation of the closure of the HSCB and the transfer of its functions into the Department, there had been a decision taken by the Department not to reappoint a CEO of the PHA following the retirement of the previous incumbent. At the time of onset of the Covid-19 pandemic there was a joint CEO between the PHA and HSCB. Arrangements had been made to support the postholder in this joint role through the appointment of two experienced deputy CEOs, one in each organisation. Prior to the onset of the pandemic, the then joint CEO had indicated her intention to retire. CMO provided advice to the Permanent Secretary that he felt an interim experienced CEO to lead the PHA was urgently required, and one was duly appointed. The individual appointed was an experienced CEO who was at that time the CEO of the RQIA. Given her role in RQIA she had significant health system level leadership experience in NI and also the advantage of coming from a health professional background having held senior professional leadership roles.

624. The PHA leadership team, the Department's CMO Group and the CMO by necessity and building on long established working relationships worked very closely as a collective leadership team to provide mutual support and assistance to ensure that the public health response was appropriately directed and coordinated, and that the PHA was best placed to meet emerging and evolving challenges and the many demands faced over the course of the pandemic.

625. It would be entirely incorrect to interpret the collective leadership model which was developed to deliver and oversee the public health elements of the pandemic response, and which served very effectively, as a transfer of powers away from the PHA. These arrangements were appropriate and proportionate in providing strategic direction and regional coordination/alignment of the public health response. They also served to optimise the public health expertise and capacity available to deliver the pandemic response in NI, while reducing the potential for duplication and fragmentation of the public health elements of the overall response.

626. Similarly in the face of very considerable public and political scrutiny, CMO anticipated that it was likely that the Department would be expected and required to lead the strategic policy aspects of the public health response in NI including: the Covid-19 testing programme; the contact tracing programme and in due course the strategic oversight and deployment of the Covid-19 vaccination programme. All these programmes were incrementally transferred fully into the PHA during the course of the pandemic.

627. This collaboration and collective endeavour was facilitated by the establishment of a number of oversight and advisory boards which were chaired by the Department and included representation from both the Department, PHA and other HSC organisations as required and appropriate. Examples of such oversight boards include the Covid-19 Vaccination Oversight Board and the Test Trace and Protect Oversight Board as outlined in paragraph 216. CMO also established the Department's Expert Advisory Group on Testing (EAG-T); which was chaired by the Deputy Director in PHA on behalf of the Department. This working group considered and developed recommendations to the Department on all aspects of Covid-19 testing including the testing of healthcare workers and community testing.

Systems for Recording Deaths during the Pandemic

628. Throughout the pandemic the PHA provided relevant clinical data, including data on deaths, to contribute to the NI Covid-19 Dashboard, which the CMO commissioned with the agreement of the Minister. The responsibility for collating clinical data remained with the PHA.

629. In the initial months of the pandemic some data was not readily available and there were considerable difficulties accessing data to understand the developing situation. This was compounded by data collection issues, for example the fact that testing capacity was limited early in the pandemic. NI was no different from other parts of the UK in this regard. From the start of the pandemic there was a need for data on levels of community transmission, data on healthcare pressures, and on disease severity including deaths. These data were not readily available, and systems had either not yet been established or if established were not linked. This is considered more fully in the UK CMO Technical report (chapter 4, pages 121-161) – [PM/69 INQ000217254 (DoH ref: MMcB001)].

630. At the outset of the pandemic, the established system for monitoring and reporting on deaths in NI was through the General Register Office (GRO); data reporting was based on death certification and by necessity included a lag time in reporting as following each death, certification needs to be completed, the death reported to the GRO, and the data analysed and reported. This system continued to operate throughout the pandemic and remained the definitive source of reporting on deaths occurring in NI.

631. In a rapidly evolving context at the outset of the pandemic the PHA established an additional reporting system to capture information on deaths occurring in HSC settings (reporting based on deaths in individuals within 28 days of a positive test). This reporting and monitoring system was established by PHA in a timely manner and it mirrored similar reporting systems established in other UK countries. The Department supported PHA as this data stream was established.

632. Care homes are formally regulated in NI and deaths occurring in care home settings are reportable to the health and care systems regulator (the Regulation and Quality Improvement Authority), as 'notifiable events'. As the pandemic progressed, the Regulation and Quality Improvement Authority was able to provide a continuing data stream on deaths occurring in these settings.

633. As summarised above, there were a number of systems in place and developed at pace to capture and record information on deaths occurring during the pandemic – these included systems operated by the General Register Office, PHA, HSC Trusts and the Regulation and Quality Improvement Authority/Care Homes. Some of these systems were established and operating before the pandemic, others were established at pace in the early stages of the pandemic. In the context of data relating to deaths in NI: because there were a number of systems operating and being established, and each was based on different reporting requirements, there was potential for confusion in the early stages of the pandemic. It was the Department's experience that all parties worked together to address and resolve any particular areas in which there was a lack of clarity.

634. This was a highly complex and fast evolving situation, and as such the PHA worked closely and at pace with public health and policy colleagues across all UK nations to agree definitions and associated systems to capture information on cases, contacts, deaths, hospitalisations etc. The approach adopted by PHA was similar to that taken by the other public health bodies/agencies in the UK. Throughout all phases of the pandemic, PHA continued to work closely with Departmental officials and colleagues across all UK nations to both capture and report public health information relating to progress of the pandemic.

635. Throughout the pandemic new data sources and information flows were established and developed. The data available to the Department particularly in the first few months of the pandemic, were very limited compared to what became available in later months and years. Development of the NI Covid-19 dashboards was central to public transparency and helped engage the public with the public health interventions required to mitigate effects of the pandemic. The PHA did not have a system to facilitate public reporting and sharing of data (relating to cases, contacts, outbreaks etc) when the pandemic commenced, the Department requested it's Information and Analysis Directorate (IAD) to develop a system to facilitate public reporting of information relating to the pandemic and this was subsequently established.

Data Modelling

636. It is now possible to undertake epidemiological analysis of disease patterns and trends in a way which was not possible at the start of the pandemic. Additional epidemiological and surveillance capacity and capability has now been developed within the PHA who currently produce a weekly Covid-19 and seasonal influenza bulletin with links to other relevant data sources.

637. The Department identified a lack of independent modelling capacity in the PHA and the wider healthcare system in general as a deficit and the CMO asked the CSA to establish a modelling group in March 2020. Membership of the modelling group was drawn from a range of organisations, including several senior staff from PHA along with others from Queens University Belfast, Ulster University, HSC Trusts and the Strategic Intelligence Board, in order to draw upon a wide range of skills and expertise.

638. The Modelling Group considered modelling from a range of sources (including its own modelling) and agreed R value(s), or more correctly an R Range, weekly or as required for most of the epidemic. SPI-M and the Four Nations Modelling Group were attended by PHA and the Department's staff who fed back to and participated in modelling group discussions. Therefore, PHA staff remained fully involved in data modelling and the calculation of "R". The modelling group did not formally report to "Gold" but informed CSA and CMO advice which was provided to the Minister and the NI Executive. Later in the pandemic this modelling capacity was developed within the PHA and the role was taken into the wider responsibilities of the PHA and the Modelling Group was stood down on the 15 February 2022.

639. The Department identified a lack of independent modelling capacity in PHA as a deficit and the CMO asked the CSA to establish a modelling group in March 2020. Membership of the modelling group was drawn from a range of organisations, including several senior staff from PHA along with others from Queens University Belfast, Ulster University, HSC Trusts and the Strategic Investment Board. The Modelling Group considered modelling from a range of sources (including its own modelling) and agreed R value(s) (or more correctly an R Range) weekly, or as required for most of the pandemic. SPI-M and the Four Nations Modelling Group were attended by PHA and Departmental staff who fed back to and participated in

modelling group discussions. The terms of reference for the Modelling Group can be found at [PM/439 - INQ000137356 (DoH ref: MMcB027)].

640. The Modelling Group considered scenarios and provided estimates of the potential effects of various interventions or counterfactual cases, which informed discussions at the Strategic Intelligence Group, and in turn the advice which was provided by the CMO and the CSO to the Minister and the NI Executive. Outputs of the modelling group were at an NI level and informed Trust specific modelling and planning which was carried out at HSB/PHA/Trust level.

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.

Personal Data

Signed: _____

8 February 2024

Dated: _____

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